

Orthopaedics: Lower - Hips & Below

A comprehensive illustrated guide to
coding and reimbursement

SAMPLE

2024

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SAMPLE

Getting Started with Coding Companion

Coding Companion for Orthopaedics — Lower: Hips and Below 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/HCPCS Codes

For ease of use, evaluation and management codes related to orthopaedics — lower: hips and below 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/HCPCS 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 Optum *Coding Companion* series display in their resequenced order. **Resequenced codes are enclosed in brackets [] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. 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.

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT code description, followed by an easy-to-understand explanation.

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

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

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

CCI Edits, RVUs, HCPCS, 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 28.3, 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 website address is <http://www.optumcoding.com/ProductUpdates/>. The 2024 edition password is: **23SPECIALTY**. 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:

28285 Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)

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

Foot
Hammertoe Operation, 28285
or
Hammertoe Repair, 28285-28286
or
Reconstruction
Toe
Hammertoe, 28285-28286

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.

Sample Page and Key

The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

11055-11057

1

- 11055** Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
- 11056** 2 to 4 lesions
- 11057** more than 4 lesions



Depiction of a single corn-like lesion on a common location of the foot

2

Explanation

The physician removes a benign hyperkeratotic skin lesion such as a corn or callus by cutting, clipping, or paring. Report 11055 when one lesion is removed; 11056 when two to four lesions are removed; and 11057 when more than four lesions are removed.

Coding Tips

Routine foot care, which includes the paring or cutting of corns and calluses, is not covered by Medicare unless the patient suffers from a condition that puts him/her at risk when these services are performed by a nonprofessional. For diabetic patients with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), see G0247. Modifier Q7, Q8, or Q9 should be used to indicate a significant systemic condition (e.g., diabetes mellitus, peripheral neuropathies involving the feet) that puts the patient at risk for problems with wound healing and potential loss of limb. It is inappropriate to report supplies when these services are performed in an emergency room. For physician office, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

- L11.0 Acquired keratosis follicularis
- L84 Corns and callosities
- L85.1 Acquired keratosis [keratoderma] palmaris et plantaris
- L85.2 Keratosis punctata (palmaris et plantaris)
- L86 Keratoderma in diseases classified elsewhere
- L87.0 Keratosis follicularis et parafollicularis in cutem penetrans
- Q82.8 Other specified congenital malformations of skin

Associated HCPCS Codes

- G0247 Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective

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sensation (LOPS) to include the local care of superficial wounds (i.e., superficial to muscle and fascia) and at least the following, if present: (1) local care of superficial wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails

AMA: 11055 2022, Feb 11056 2022, Feb 11057 2022, Feb

7

Relative Value Units/Medicare Edits

8

Non-Facility RVU	Work	PE	MP	Total
11055	0.35	1.77	0.04	2.16
11056	0.5	1.93	0.04	2.47
11057	0.65	2.01	0.05	2.71
Facility RVU	Work	PE	MP	Total
11055	0.35	0.08	0.04	0.47
11056	0.5	0.11	0.04	0.65
11057	0.65	0.14	0.05	0.84

	FUD	Status	MUE	Modifiers			IOM Reference	
11055	0	R	1(2)	51	N/A	N/A	N/A	None
11056	0	R	1(2)	51	N/A	N/A	N/A	
11057	0	R	1(2)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

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anomaly. Irregularity in the structure or position of an organ or tissue.

benign lesion. Neoplasm or change in tissue that is not cancerous (nonmalignant).

callosities. Localized, hardened patches of overgrowth on the epidermis caused by friction or pressure.

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

keratoderma. Excessive growth of a horny, callous layer on the skin in three typical patterns: diffused over the palm and sole, focal with large keratin masses at points of friction, and punctate with tiny drops of keratin on the palmoplantar surface.

keratosis. Skin condition characterized by a wart-like or callus-type localized overgrowth, hardening, or thickening of the upper skin layer as a result of overproduction of the protein keratin.

lesion. Area of damaged tissue that has lost continuity or function, due to disease or trauma. Lesions may be located on internal structures such as the brain, nerves, or kidneys, or visible on the skin.

paring. Cutting away an edge or a surface.

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

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2024.

The following icons are used in *Coding Companion*:

- This CPT code is new for 2024.
- ▲ This CPT code description is revised for 2024.
- + 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 audio-visual 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 93 or 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.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services, when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96160	96161	97802	97803	97804
99406	99407	99408	99409	99497	99498	

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 Optum 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.

The 2023 Medicare edits were not available at the time this book went to press. Updated 2023 values will be posted at <https://www.optumcoding.com/ProductUpdates/>. The 2023 edition password is **23SPECIALTY**.

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

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

► The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, “Hospital Inpatient and Observation Care,” special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service ◀

Classification of Evaluation and Management (E/M) Services

► The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care 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 inpatient and observation care 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 codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code. ◀

AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

New and Established Patients

► 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 evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty and subspecialty who belongs to the same group practice, within the past three years.

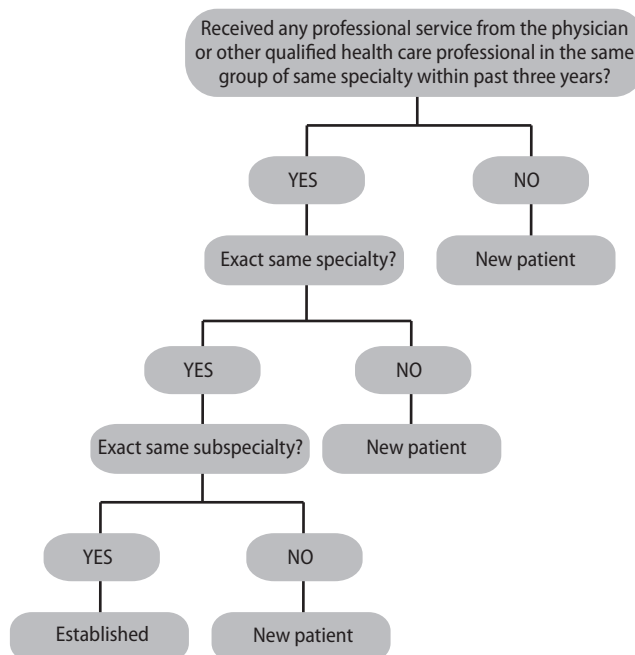
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty and subspecialty who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient’s encounter will be classified as it would have been by the physician or other 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 subspecialty 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 for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



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 not considered 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 patients admitted and discharged from inpatient or observation care on the same date, see 99234-99236. For prolonged services with 99205, see 99417; for Medicare, see G2212. Medicare has identified these codes as telehealth/telemedicine services. Commercial payers should be contacted regarding their coverage guidelines. 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 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Mar; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,May; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Jul; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99203** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Mar; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,May; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Jul; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99204** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Mar; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,May; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Jul; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99205** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Mar; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,May; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Jul; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan

Relative Value Units/Medicare Edits

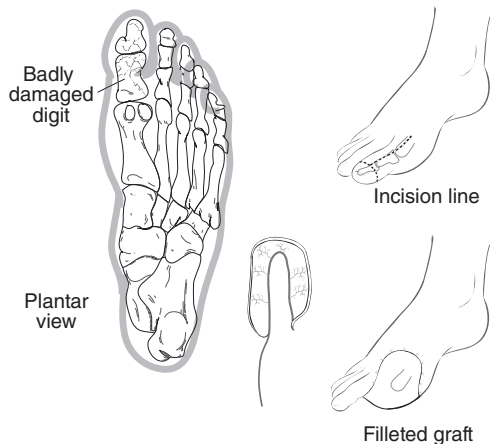
Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.12	0.09	2.14
99203	1.6	1.52	0.17	3.29
99204	2.6	2.06	0.24	4.9
99205	3.5	2.66	0.32	6.48
Facility RVU	Work	PE	MP	Total
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.17	2.44
99204	2.6	1.11	0.24	3.95
99205	3.5	1.54	0.32	5.36

	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

14350

14350 Filleted finger or toe flap, including preparation of recipient site



A fillet flap of a toe is performed, in addition to preparation of the recipient site

Explanation

The physician creates a filleted toe flap to repair a large deficit on the foot. The physician makes a bilateral longitudinal incision and dissects the tissue away from the donor site, protecting vascular integrity. The recipient site is prepared and the flap is rotated into place. Excess tissue is excised and the wound is sutured in layers.

Coding Tips

When this code is used to report repair of traumatic wounds, the procedure must have been previously planned and developed by the physician to affect the repair. This code does not apply when direct closure or rearrangement of traumatized tissue incidentally results in these configurations. Preparation of the recipient site is included and should not be reported separately. Any skin grafting required to close the secondary defect is reported separately. Some payers may require the use of HCPCS Level II modifiers TA-T9 to identify the specific digit involved. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage. For an intralesional injection to limit scarring, see 11900.

ICD-10-CM Diagnostic Codes

- L97.514 Non-pressure chronic ulcer of other part of right foot with necrosis of bone
- L97.516 Non-pressure chronic ulcer of other part of right foot with bone involvement without evidence of necrosis
- L97.518 Non-pressure chronic ulcer of other part of right foot with other specified severity
- L97.524 Non-pressure chronic ulcer of other part of left foot with necrosis of bone
- L97.526 Non-pressure chronic ulcer of other part of left foot with bone involvement without evidence of necrosis
- L97.528 Non-pressure chronic ulcer of other part of left foot with other specified severity
- S92.411B Displaced fracture of proximal phalanx of right great toe, initial encounter for open fracture
- S92.421B Displaced fracture of distal phalanx of right great toe, initial encounter for open fracture

- S92.511B Displaced fracture of proximal phalanx of right lesser toe(s), initial encounter for open fracture
- S92.521B Displaced fracture of middle phalanx of right lesser toe(s), initial encounter for open fracture
- S92.531B Displaced fracture of distal phalanx of right lesser toe(s), initial encounter for open fracture
- S97.111A Crushing injury of right great toe, initial encounter
- S97.112A Crushing injury of left great toe, initial encounter
- S97.121A Crushing injury of right lesser toe(s), initial encounter
- S97.122A Crushing injury of left lesser toe(s), initial encounter

AMA: 14350 2022,Nov; 2022,Feb; 2021,Aug; 2021,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
14350	11.05	7.8	1.16	20.01
Facility RVU	Work	PE	MP	Total
14350	11.05	7.8	1.16	20.01

	FUD	Status	MUE	Modifiers			IOM Reference	
14350	90	A	2(3)	51	N/A	N/A	80*	None

* with documentation

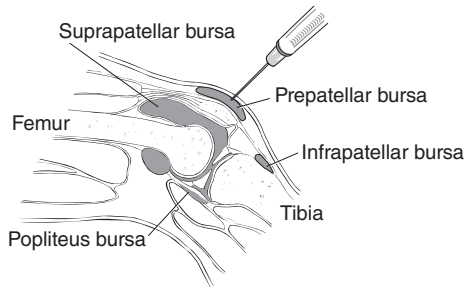
Terms To Know

flap graft. Mass of flesh and skin partially excised from its location but retaining its blood supply, grafted onto another site to repair adjacent or distant defects.

wound repair. Surgical closure of a wound is divided into three categories: simple, intermediate, and complex. **simple repair:** Surgical closure of a superficial wound, requiring single layer suturing of the skin epidermis, dermis, or subcutaneous tissue. **intermediate repair:** Surgical closure of a wound requiring closure of one or more of the deeper subcutaneous tissue and non-muscle fascia layers in addition to suturing the skin; contaminated wounds with single layer closure that need extensive cleaning or foreign body removal. **complex repair:** Repair of wounds requiring more than layered closure (debridement, scar revision, stents, retention sutures).

20610-20611

- 20610** Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
- 20611** with ultrasound guidance, with permanent recording and reporting



Explanation

After administering a local anesthetic, the physician inserts a needle through the skin and into a joint or bursa. A fluid sample may be removed from the joint for examination or a fluid may be injected for lavage or drug therapy. The needle is then withdrawn and pressure is applied to stop any bleeding. Report 20610 for a major joint or bursa injection or aspiration, such as of the shoulder, hip, knee joint, or subacromial bursa, without ultrasound guidance; 20611 for a major joint or bursa, with ultrasound guidance, including permanent record and report.

Coding Tips

Code selection depends on the size of the joint and whether the procedure was performed with or without ultrasonic guidance. If fluoroscopic, CT, or MRI guidance is performed, see 77002, 77012, and 77021. Do not report 20610–20611 with 27369 or 76942. When more than one procedure is performed on the same joint, do not report separately. For aspiration or injection of a ganglion cyst, any location, see 20612. For injection of autologous, adipose-derived regenerative cells, see 0489T-0490T.

ICD-10-CM Diagnostic Codes

- M00.851 Arthritis due to other bacteria, right hip ✓
- M00.861 Arthritis due to other bacteria, right knee ✓
- M05.251 Rheumatoid vasculitis with rheumatoid arthritis of right hip ✓
- M05.261 Rheumatoid vasculitis with rheumatoid arthritis of right knee ✓
- M05.751 Rheumatoid arthritis with rheumatoid factor of right hip without organ or systems involvement ✓
- M05.761 Rheumatoid arthritis with rheumatoid factor of right knee without organ or systems involvement ✓
- M06.051 Rheumatoid arthritis without rheumatoid factor, right hip ✓
- M06.061 Rheumatoid arthritis without rheumatoid factor, right knee ✓
- M06.251 Rheumatoid bursitis, right hip ✓
- M06.261 Rheumatoid bursitis, right knee ✓
- M07.651 Enteropathic arthropathies, right hip ✓
- M07.661 Enteropathic arthropathies, right knee ✓
- M10.051 Idiopathic gout, right hip ✓
- M10.061 Idiopathic gout, right knee ✓
- M11.851 Other specified crystal arthropathies, right hip ✓
- M11.861 Other specified crystal arthropathies, right knee ✓
- M12.551 Traumatic arthropathy, right hip ✓
- M12.561 Traumatic arthropathy, right knee ✓

- M16.51 Unilateral post-traumatic osteoarthritis, right hip ✓
- M17.31 Unilateral post-traumatic osteoarthritis, right knee ✓
- M23.8X1 Other internal derangements of right knee ✓
- M25.051 Hemarthrosis, right hip ✓
- M25.061 Hemarthrosis, right knee ✓
- M25.451 Effusion, right hip ✓
- M25.461 Effusion, right knee ✓
- M65.151 Other infective (teno)synovitis, right hip ✓
- M65.161 Other infective (teno)synovitis, right knee ✓
- M70.41 Prepatellar bursitis, right knee ✓
- M70.61 Trochanteric bursitis, right hip ✓

AMA: 20610 2019, Aug; 2017, May; 2017, Apr 20611 2019, Aug

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
20610	0.79	1.01	0.12	1.92
20611	1.1	1.71	0.14	2.95
Facility RVU	Work	PE	MP	Total
20610	0.79	0.42	0.12	1.33
20611	1.1	0.5	0.14	1.74

	FUD	Status	MUE	Modifiers				IOM Reference
20610	0	A	2(3)	51	50	N/A	N/A	None
20611	0	A	2(3)	51	50	N/A	N/A	

* with documentation

Terms To Know

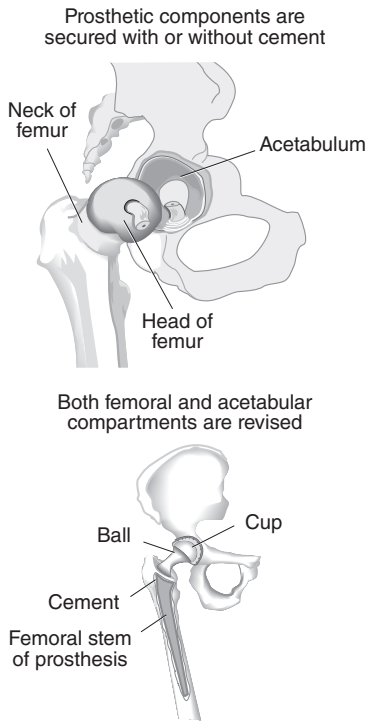
arthropathy. Disease of the joints.

aspiration. Drawing fluid out by suction.

bursitis. Inflammation of the fluid-filled cavity or sac that reduces friction between neighboring, moving parts.

27134

27134 Revision of total hip arthroplasty; both components, with or without autograft or allograft



Explanation

The physician revises a total hip arthroplasty. With the patient in a lateral decubitus position, the physician may access the hip through the previous hip surgery incision. Muscles are reflected. A trochanteric osteotomy may be performed with an oscillating saw. The physician incises the hip joint capsule. Any scar tissue is removed. The physician manually dislocates the hip. Cement is removed from the upper portion of the femoral stem with a motorized or hand instrument. The stem may be removed. If the stem has fractured, the physician may drill a hole in the femoral shaft so that an instrument may remove the broken portion. The physician removes scar tissue and cement from around the acetabular component with chisels and gouges. The acetabular component is removed from its bed. The physician reconstructs the acetabulum with cement or screws and bone graft. The new femoral stem is inserted into the femoral shaft. The physician may augment the area with an autograft or allograft. The physician reduces the hip and closes the capsule. The greater trochanter is wired into place. Suction drains may be placed in the wound. The incision is repaired in layers with sutures, staples, and/or Steri-strips.

Coding Tips

This code is for a revision of total hip arthroplasty, which includes the acetabular and femoral components. Trochanteric osteotomy and repair, as well as iliopsoas tenotomy, are integral to 27134 and should not be reported separately. Any bone graft harvest is not reported separately. For initial arthroplasty, both components, see 27130. For partial hip replacement, see 27125. For removal of a hip prosthesis, without concurrent revision/replacement, see 27090–27091.

ICD-10-CM Diagnostic Codes

- M97.01XA Periprosthetic fracture around internal prosthetic right hip joint, initial encounter
- M97.01XD Periprosthetic fracture around internal prosthetic right hip joint, subsequent encounter
- T84.010A Broken internal right hip prosthesis, initial encounter
- T84.020A Dislocation of internal right hip prosthesis, initial encounter
- T84.030A Mechanical loosening of internal right hip prosthetic joint, initial encounter
- T84.050A Periprosthetic osteolysis of internal prosthetic right hip joint, initial encounter
- T84.058A Periprosthetic osteolysis of other internal prosthetic joint, initial encounter
- T84.060A Wear of articular bearing surface of internal prosthetic right hip joint, initial encounter
- T84.068A Wear of articular bearing surface of other internal prosthetic joint, initial encounter
- T84.51XA Infection and inflammatory reaction due to internal right hip prosthesis, initial encounter
- T84.81XA Embolism due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
- T84.82XA Fibrosis due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
- T84.83XA Hemorrhage due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
- T84.84XA Pain due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
- T84.85XA Stenosis due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
- T84.86XA Thrombosis due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
- Z96.641 Presence of right artificial hip joint

AMA: 27134 2021, Sep; 2019, May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
27134	30.28	19.82	6.22	56.32
Facility RVU	Work	PE	MP	Total
27134	30.28	19.82	6.22	56.32

	FUD	Status	MUE	Modifiers			IOM Reference	
27134	90	A	1(2)	51	50	62*	80	None

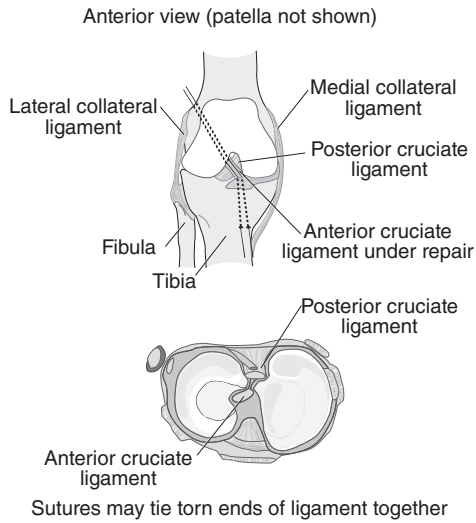
* with documentation

Terms To Know

- allograft.** Graft from one individual to another of the same species.
- arthroplasty.** Surgical reconstruction of a joint to improve function and reduce pain; may involve partial or total joint replacement.
- autograft.** Tissue harvested from the same individual at one anatomical site and grafted to another separate anatomical site.
- dislocation.** Displacement of a bone in relation to its neighboring tissue, especially a joint.

27405-27409

27405 Repair, primary, torn ligament and/or capsule, knee; collateral
27407 cruciate
27409 collateral and cruciate ligaments



Explanation

For a primary collateral repair (27405), the physician makes an incision on the lateral or medial aspect of the knee, depending on which ligament is torn (medial collateral or lateral collateral). Sutures may be used to tie the torn ends together. If the attachment of the ligament to the bone is torn away, a screw may be used for fixation. For a cruciate ligament primary repair (27407), an incision is made to gain access into the knee joint (the physician may use the arthroscope for part of the procedure). Screws and/or sutures are used to reattach the torn end to the bone. Both collateral and cruciate ligaments are repaired in 27409. Incisions are closed with sutures, staples, and/or Steri-strips. A temporary drain may be applied.

Coding Tips

When 27405, 27407, or 27409 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. For ligamentous reconstruction (augmentation), extra-articular and/or intra-articular, see 27427–27429. Note that 27427–27429 are reported in addition to the primary repair.

ICD-10-CM Diagnostic Codes

- M23.51 Chronic instability of knee, right knee ✓
- M23.52 Chronic instability of knee, left knee ✓
- M23.611 Other spontaneous disruption of anterior cruciate ligament of right knee ✓
- M23.612 Other spontaneous disruption of anterior cruciate ligament of left knee ✓
- M23.621 Other spontaneous disruption of posterior cruciate ligament of right knee ✓
- M23.622 Other spontaneous disruption of posterior cruciate ligament of left knee ✓
- M23.631 Other spontaneous disruption of medial collateral ligament of right knee ✓
- M23.632 Other spontaneous disruption of medial collateral ligament of left knee ✓

- M23.641 Other spontaneous disruption of lateral collateral ligament of right knee ✓
- M23.642 Other spontaneous disruption of lateral collateral ligament of left knee ✓
- S83.411A Sprain of medial collateral ligament of right knee, initial encounter ✓
- S83.412A Sprain of medial collateral ligament of left knee, initial encounter ✓
- S83.421A Sprain of lateral collateral ligament of right knee, initial encounter ✓
- S83.422A Sprain of lateral collateral ligament of left knee, initial encounter ✓
- S83.511A Sprain of anterior cruciate ligament of right knee, initial encounter ✓
- S83.512A Sprain of anterior cruciate ligament of left knee, initial encounter ✓
- S83.521A Sprain of posterior cruciate ligament of right knee, initial encounter ✓
- S83.522A Sprain of posterior cruciate ligament of left knee, initial encounter ✓

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
27405	9.08	9.27	1.83	20.18
27407	10.85	10.66	2.23	23.74
27409	13.71	12.22	2.83	28.76
Facility RVU	Work	PE	MP	Total
27405	9.08	9.27	1.83	20.18
27407	10.85	10.66	2.23	23.74
27409	13.71	12.22	2.83	28.76

	FUD	Status	MUE	Modifiers				IOM Reference
27405	90	A	1(3)	51	50	62*	80	None
27407	90	A	1(3)	51	50	62*	80	
27409	90	A	1(2)	51	50	62*	80	

* with documentation

Terms To Know

arthroscopy. Use of an endoscope to examine the interior of a joint (diagnostic) or to perform surgery on joint structures (therapeutic).

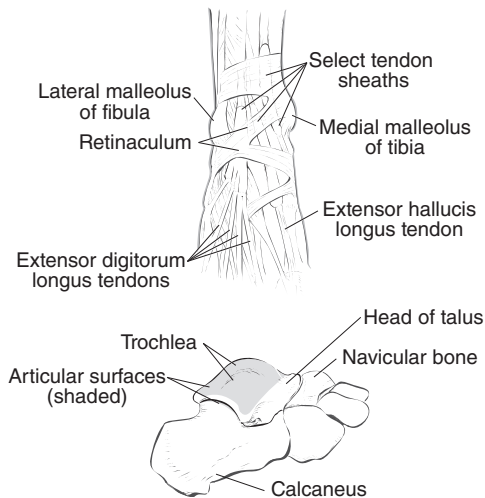
capsule. Structure made of cartilage, fibrous, membranous, or fatty tissue that encloses another structure or body part, such as a joint or the lens of the eye.

ligament. Band or sheet of fibrous tissue that connects the articular surfaces of bones or supports visceral organs.

sprain and strain. Injuries to a joint, in which the fibers of supporting ligaments or muscles are overstretched or slightly ruptured, with the ligaments and muscles maintaining continuity.

27625-27626

27625 Arthrotomy, with synovectomy, ankle;
27626 including tenosynovectomy



Explanation

In 27625, the physician performs an arthrotomy of the ankle and removes the synovium. An incision is made over the ankle. The soft tissues are dissected away and the joint capsule is exposed. An incision is made through the capsule and into the joint. The synovium is removed through the incision. The wound is irrigated with antibiotic solution and the incision is closed in layers with sutures, staples, and/or Steri-strips. In 27626, to correct thickening of the synovium, the physician makes an incision over the tendon and exposes the tendon sheath. The synovium is the lining that bathes the joint in fluid. The physician removes the affected sheath from the tendon and the joint space is opened and the synovium is removed. The wound is irrigated and closed with sutures.

Coding Tips

For arthroscopic synovectomy (partial), see 29895. For arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of a loose or foreign body, see 27620.

ICD-10-CM Diagnostic Codes

- M05.471 Rheumatoid myopathy with rheumatoid arthritis of right ankle and foot
- M05.472 Rheumatoid myopathy with rheumatoid arthritis of left ankle and foot
- M05.571 Rheumatoid polyneuropathy with rheumatoid arthritis of right ankle and foot
- M05.572 Rheumatoid polyneuropathy with rheumatoid arthritis of left ankle and foot
- M05.771 Rheumatoid arthritis with rheumatoid factor of right ankle and foot without organ or systems involvement
- M05.772 Rheumatoid arthritis with rheumatoid factor of left ankle and foot without organ or systems involvement
- M05.871 Other rheumatoid arthritis with rheumatoid factor of right ankle and foot
- M05.872 Other rheumatoid arthritis with rheumatoid factor of left ankle and foot

- M06.071 Rheumatoid arthritis without rheumatoid factor, right ankle and foot
- M06.072 Rheumatoid arthritis without rheumatoid factor, left ankle and foot
- M06.871 Other specified rheumatoid arthritis, right ankle and foot
- M06.872 Other specified rheumatoid arthritis, left ankle and foot
- M06.89 Other specified rheumatoid arthritis, multiple sites
- M12.271 Villonodular synovitis (pigmented), right ankle and foot
- M12.272 Villonodular synovitis (pigmented), left ankle and foot
- M19.071 Primary osteoarthritis, right ankle and foot
- M19.072 Primary osteoarthritis, left ankle and foot
- M19.171 Post-traumatic osteoarthritis, right ankle and foot
- M19.172 Post-traumatic osteoarthritis, left ankle and foot
- M19.271 Secondary osteoarthritis, right ankle and foot
- M19.272 Secondary osteoarthritis, left ankle and foot
- M65.871 Other synovitis and tenosynovitis, right ankle and foot
- M65.872 Other synovitis and tenosynovitis, left ankle and foot

AMA: 27625 2022, Oct 27626 2022, Oct

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
27625	8.49	7.23	1.32	17.04
27626	9.1	7.43	1.33	17.86
Facility RVU	Work	PE	MP	Total
27625	8.49	7.23	1.32	17.04
27626	9.1	7.43	1.33	17.86

	FUD	Status	MUE	Modifiers				IOM Reference
27625	90	A	1(2)	51	50	62*	80	None
27626	90	A	1(2)	51	50	N/A	80	

* with documentation

Terms To Know

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.

synovectomy. Removal of the synovial membrane lining of a joint.

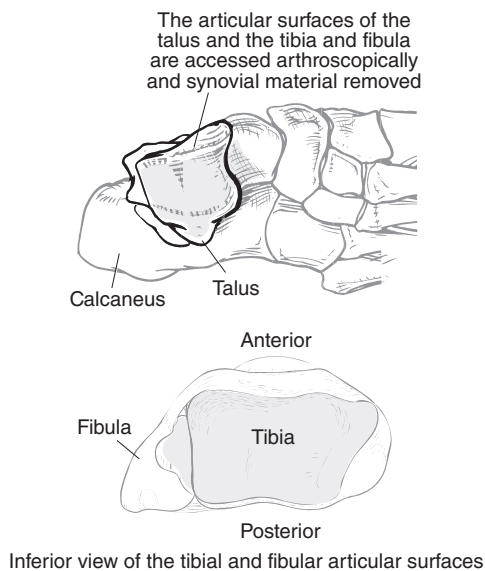
synovia. Clear fluid lubricant of joints, bursae, and tendon sheaths, secreted by the synovial membrane.

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

villonodular synovitis. Inflammation of the synovial membrane due to excessive synovial tissue formation, especially in the knee.

29895

29895 Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; synovectomy, partial



Explanation

The physician performs arthroscopy on an ankle joint to remove the synovial lining of the joint. With the patient soothed by general anesthesia, the physician makes two to four 0.5 cm skin incisions around the ankle. The physician introduces the arthroscope into the ankle and conducts an exam. The offending synovial tissue is identified. Additional instruments are placed through the incisions. Using the arthroscope, the physician uses these instruments to excise the synovium. The joint is irrigated and the skin portals are closed. A dressing is applied.

Coding Tips

Surgical arthroscopy includes a diagnostic arthroscopy. CPT guidelines indicate that when the physician cannot complete the procedure through the arthroscope, and an open procedure is performed, list the open procedure first, code the arthroscope as diagnostic, and append modifier 51. Medicare and some other third-party payers do not allow a scope procedure when performed in conjunction with a related open procedure. Check with individual payers regarding their specific coding guidelines. According to CPT guidelines, the application and removal of the first cast, splint, or traction device are included in the codes that appear in the Musculoskeletal System section of CPT. Supplies may be reported separately. Modifier 56 should not be reported for preoperative management of a fracture. Removal of a cast by a provider, other than the provider who applied the cast, can be reported with cast removal codes 29700, 29705, and 29710. Cast, splint, or strapping (29000-29750) and/or traction device (20690, 20692) replacement during or after the global period of a procedure may be reported separately. For arthrotomy, with synovectomy, see 27625; with tenosynovectomy, see 27626. For radiology services, see 73600-73615.

ICD-10-CM Diagnostic Codes

- M05.471 Rheumatoid myopathy with rheumatoid arthritis of right ankle and foot
- M06.271 Rheumatoid bursitis, right ankle and foot
- M06.371 Rheumatoid nodule, right ankle and foot
- M12.271 Villonodular synovitis (pigmented), right ankle and foot

- M12.571 Traumatic arthropathy, right ankle and foot
- M19.071 Primary osteoarthritis, right ankle and foot
- M25.371 Other instability, right ankle
- M25.374 Other instability, right foot
- M25.671 Stiffness of right ankle, not elsewhere classified
- M25.674 Stiffness of right foot, not elsewhere classified
- S96.091A Other injury of muscle and tendon of long flexor muscle of toe at ankle and foot level, right foot, initial encounter
- S96.191A Other specified injury of muscle and tendon of long extensor muscle of toe at ankle and foot level, right foot, initial encounter
- S96.291A Other specified injury of intrinsic muscle and tendon at ankle and foot level, right foot, initial encounter
- S96.891A Other specified injury of other specified muscles and tendons at ankle and foot level, right foot, initial encounter
- S99.811A Other specified injuries of right ankle, initial encounter
- S99.821A Other specified injuries of right foot, initial encounter

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
29895	7.13	5.72	1.02	13.87
Facility RVU	Work	PE	MP	Total
29895	7.13	5.72	1.02	13.87

	FUD	Status	MUE	Modifiers				IOM Reference
29895	90	A	1(2)	51	50	62*	80	None

* with documentation

Terms To Know

bursitis. Inflammation of a bursa.

rheumatoid arthritis. Autoimmune disease causing pain, stiffness, inflammation, and possibly joint destruction.

Correct Coding Initiative Update 28.3

◆Indicates Mutually Exclusive Edit

- 0054T** 0213T, 0216T, 0708T-0709T, 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, 0708T-0709T, 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
- 0101T** 0213T, 0216T, 0508T, 0512T, 0513T, 0708T-0709T, 36000, 36410, 36591-36592, 43752, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 69990, 76881-76882, 76977, 76998-76999, 96360, 96365, 96372, 96374-96377, 96523, 99446-99449, 99451-99452
- 0102T** 0101T*, 0213T, 0216T, 0508T, 0512T*, 0708T-0709T, 36000, 36410, 36591-36592, 43752, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 69990, 76881-76882, 76977, 76998-76999, 96360, 96365, 96372, 96374-96377, 96523, 99446-99449, 99451-99452
- 0200T** 01937-01939, 01940-01942, 0213T, 0216T, 0333T, 0464T, 0596T-0597T, 0708T-0709T, 10005, 10007, 10009, 10011, 10021, 11000-11006, 11042-11047, 20220-20225, 20240, 22310-22315, 22505, 36000, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 38220, 38222-38230, 38232, 43752, 51701-51703, 61650, 62322-62323, 62326-62327, 63707, 63709, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 75872, 76000, 77002-77003, 92652-92653, 93000-93010, 93040-93042, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95860-95870, 95907-95913, 95925-95933, 95937-95940, 95955, 96360, 96365, 96372, 96374-96377, 96523, 97597-97598, 97602, 99155, 99156, 99157, 99446-99449, 99451-99452, G0453, G0471
- 0201T** 01937-01939, 01940-01942, 0200T, 0213T, 0216T, 0333T, 0464T, 0596T-0597T, 0708T-0709T, 10005, 10007, 10009, 10011, 10021, 11000-11006, 11042-11047, 20220-20225, 20240, 22310-22315, 22505, 36000, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 38220, 38222-38230, 38232, 43752, 51701-51703, 61650, 62322-62323, 62326-62327, 63707, 63709, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 75872, 76000, 77002-77003, 92652-92653, 93000-93010, 93040-93042, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95860-95870, 95907-95913, 95925-95933, 95937-95940, 95955, 96360, 96365, 96372, 96374-96377, 96523, 97597-97598, 97602, 99155, 99156, 99157, 99446-99449, 99451-99452, G0453, G0471
- 0202T** 0213T, 0216T, 0333T, 0464T, 0565T, 0596T-0597T, 0708T-0709T, 11000-11006, 11042-11047, 15769, 20240*, 20251*, 22505, 22511, 22514, 22853-22854, 22859, 36000, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 38220, 38222-38230, 38232, 43752, 51701-51703, 61650, 62290, 62320-62327, 63707, 63709, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 76000, 77001-77003, 92652-92653, 93000-93010, 93040-93042, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95860-95870, 95907-95913, 95925-95933, 95937-95940, 95955, 96360, 96365, 96372, 96374-96377, 96523, 97597-97598, 97602, 99155, 99156, 99157, 99446-99449, 99451-99452, G0453, G0471

- 0213T** 01991-01992, 0333T, 0464T, 0545T, 20550-20551, 20600, 20605, 20610, 36000, 36140, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 43752, 51701-51703, 62320-62321, 62324-62325, 64400, 64405-64408, 64415-64435, 64445-64450, 64479, 64483, 64486-64489, 64505, 64510-64530, 69990, 76000, 76380, 76800, 76942, 76998, 77001-77003, 77012, 77021, 92652-92653, 93000-93010, 93040-93042, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95860-95870, 95907-95913, 95925-95933, 95937-95940, 95955, 96360, 96365, 96372, 96374-96377, 96523, 99155, 99156, 99157, 99446-99449, 99451-99452, G0453, G0459, G0471, J2001
- 0214T** 0333T, 0464T, 0596T-0597T, 36591-36592, 51701-51703, 76000, 76380, 76800, 76942, 76998, 77001-77003, 77012, 77021, 92652-92653, 95822, 95860-95870, 95907-95913, 95925-95933, 95937-95940, 96523, 99446-99449, 99451-99452, G0453, G0471
- 0215T** 0333T, 0464T, 0596T-0597T, 36591-36592, 51701-51703, 76000, 76380, 76800, 76942, 76998, 77001-77003, 77012, 77021, 92652-92653, 95822, 95860-95870, 95907-95913, 95925-95933, 95937-95940, 96523, 99446-99449, 99451-99452, G0453, G0471
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