Optum

Coding Companion

ENT/Allergy/ Pulmonology

A comprehensive illustrated guide to coding and reimbursement

2027

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Getting Started with Coding Companion

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

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

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to ENT/allergy/pulmonology are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT/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/HCPCS code description, followed by an easy-to-understand explanation, relative value units, and Medicare edits. The Relative Value Unit/Medicare Edits table will not be included with any CPT/HCPCS code with a "0" (zero) value.

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

- HCPCS
- E/M
- 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, 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 32.3, 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 2027 edition password is: **XXXXX** Log in frequently to ensure you receive the most current updates.

Index

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

69501 Transmastoid antrotomy (simple mastoidectomy)

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

Antrotomy
Transmastoid, 69501

or **Excision**
Mastoid
Simple, 69501

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xv 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

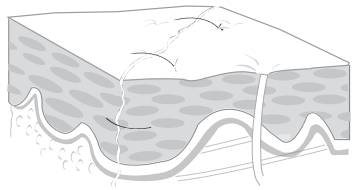
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

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.

12001-12007

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



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

Explanation

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

Coding Tips

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

ICD-10-CM Diagnostic Codes

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

Associated HCPCS Codes

G0168 Wound closure utilizing tissue adhesive(s) only

AMA: **12001** 2023,Aug; 2023,Mar; 2022,Aug; 2022,Feb; 2021,Aug; 2018, **12002** 2023,Aug; 2023,Jul; 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **120** 2023,Aug; 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12005** 2023,Aug; 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12006** 2023,Aug; 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12007** 2023,Aug; 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
12001	0.84	1.84	0.16	2.84
12002	1.14	2.08	0.22	3.44
12004	1.44	2.28	0.29	4.01
12005	1.97	2.97	0.4	5.34
12006	2.39	3.3	0.47	6.16
12007	2.9	3.51	0.58	6.99
Facility RVU	**Work**	**PE**	**MP**	**Total**
12001	0.84	0.34	0.16	1.34
12002	1.14	0.4	0.22	1.76
12004	1.44	0.47	0.29	2.2
12005	1.97	0.46	0.4	2.83
12006	2.39	0.6	0.47	3.46
12007	2.9	0.82	0.58	4.3

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

* with documentation

Terms To Know

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

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

injury. Harm or damage sustained by the body.

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

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

suture. Numerous stitching techniques employed in wound closure.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2027

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2027
- ▲ This CPT code description is revised for 2027
- ✚ 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. Note: This icon is not appended to the synchronous audio-video visit codes 98000-98007.

The Centers for Medicare and Medicaid Services (CMS) have identified services that may be performed via telehealth. 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	96041
96110	96116	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
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 a 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:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ☑ 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 2026.

Relative Value Units

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

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

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs when the technical (modifier TC) or professional (modifier 26) component of a procedure is provided.

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 total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

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 total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

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 total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

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, a total time of 15 minutes must be met or exceeded on the day of the encounter. Report 99203 for a visit requiring a low level of MDM or meeting or exceeding 30 minutes of total time; 99204 for a visit requiring a moderate level of MDM or meeting or exceeding 45 minutes of total time; and 99205 for a visit requiring a high level of MDM or meeting or exceeding 60 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. Alternatively, 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. Medicare has identified these codes as telehealth/telemedicine services. CMS requires the use of a place of service (POS) indicator: POS 02 for telehealth services when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. For prolonged services applicable to 99205, see 99417; for Medicare, see G2212. Medicare and commercial payers should be contacted regarding their coverage guidelines. For office or other outpatient services for an established patient, see 99211-99215.

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** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99203** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99204** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99205** 2024,Sep; 2024,Mar; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.16	0.08	2.17
99203	1.6	1.59	0.16	3.35
99204	2.6	2.18	0.24	5.02
99205	3.5	2.79	0.33	6.62
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.4	0.08	1.41
99203	1.6	0.68	0.16	2.44
99204	2.6	1.13	0.24	3.97
99205	3.5	1.57	0.33	5.4

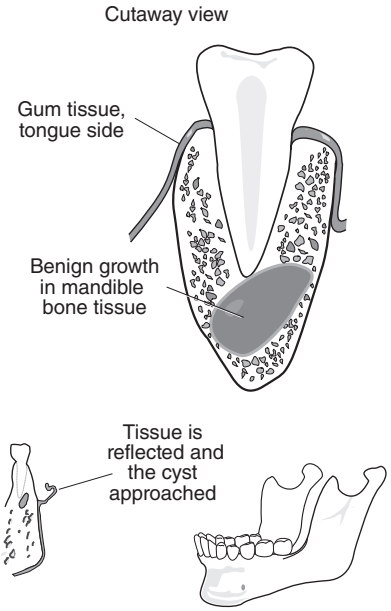
	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

● New ▲ Revised + Add On ★ Telemedicine [Resequenced] ☑ Laterality

21040

21040 Excision of benign tumor or cyst of mandible, by enucleation and/or curettage



Explanation

The physician removes a cyst or benign tumor from the mandible by enucleation and/or curettage, not requiring osteotomy. Using an intraoral approach, the physician incises and reflects a mucosal flap of tissue inside the mouth overlying the tumor. In an extraoral approach, the physician approaches the defect through an external skin incision. The tumor is identified and removed from the mandible by scraping with a curette or by cutting the tumor out in such a way as to leave it intact and remove it whole. The mucosal flap is sutured primarily or subcutaneous tissue and skin incisions on the face are closed with layered sutures.

Coding Tips

When 21040 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. If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report. Code 21040 is used to report enucleation and/or curettage that does not require osteotomy. For excision of benign tumors or cysts of the mandible that do require an osteotomy, see 21046–21047. An excisional biopsy is not reported separately when a therapeutic excision is performed during the same surgical session. Local anesthesia is included in this service. If a specimen is transported to an outside laboratory, report 99000 for handling or conveyance. Report any free grafts or flaps separately. For biopsy of bone, see 20220 and 20240. For excision of a malignant tumor of the mandible, see 21044.

ICD-10-CM Diagnostic Codes

D16.5	Benign neoplasm of lower jaw bone
K09.0	Developmental odontogenic cysts
K09.1	Developmental (nonodontogenic) cysts of oral region
M27.49	Other cysts of jaw
M27.8	Other specified diseases of jaws

AMA: **21040** 2021,Dec; 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21040	4.91	8.52	0.48	13.91
Facility RVU	**Work**	**PE**	**MP**	**Total**
21040	4.91	5.49	0.48	10.88

	FUD	Status	MUE	Modifiers				IOM Reference
21040	90	A	2(3)	51	N/A	N/A	N/A	None

* with documentation

Terms To Know

benign. Mild or nonmalignant in nature.

curettage. Removal of tissue by scraping.

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

enucleation. Removal of a growth or organ cleanly so as to extract it in one piece.

excision. Surgical removal of an organ or tissue.

exostosis. Abnormal formation of a benign bony growth.

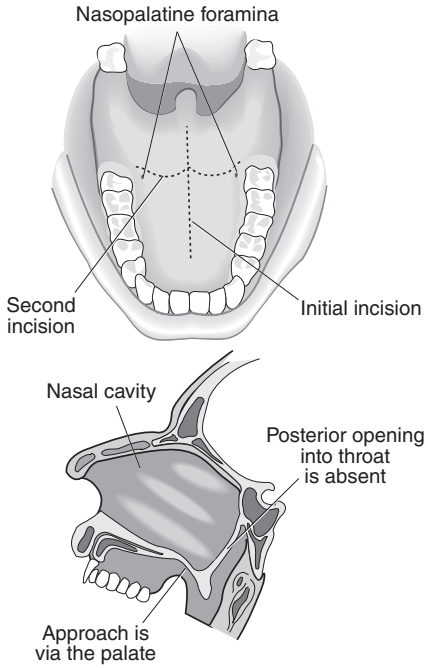
flap. Mass of flesh and skin partially excised from its location but retaining its blood supply that is moved to another site to repair adjacent or distant defects.

neoplasm. New abnormal growth, tumor.

tumor. Pathological swelling or enlargement; a neoplastic growth of uncontrolled, abnormal multiplication of cells.

30545

30545 Repair choanal atresia; transpalatine



Explanation

The physician reconstructs the congenitally or acquired absent openings between the nasal cavity and the pharynx (throat). Topical vasoconstrictive agents are applied to the nasal mucosa. Local anesthesia is injected in the nasal mucosa and maxilla. A midpalatal incision is made extending posterior to the nasopalatine foramen to the soft palate. The mucoperiosteum is elevated, exposing the hard palate. Using drills and chisels, the physician creates bony windows at the posterior hard palate, removing bony obstructions between the nasal floor and the pharynx. The physician places rubber tubes along the nasal floor through the new openings into the nasopharynx. The rubber tubes are sutured to the nasal columella. The palatal incision is closed in a single layer. The rubber tubes remain for a three-to-eight-week healing period to ensure patency of the new posterior nares after removal.

Coding Tips

Removal of rubber tubes is not reported separately. Topical vasoconstrictive agents and local anesthesia are not reported separately. For intranasal repair of choanal atresia, see 30540. Do not append modifier 63 to 30545 as the description or nature of the procedure includes infants up to 4 kg.

ICD-10-CM Diagnostic Codes

M95.0 Acquired deformity of nose

Q30.0 Choanal atresia

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
30545	11.62	16.96	1.69	30.27
Facility RVU	**Work**	**PE**	**MP**	**Total**
30545	11.62	16.96	1.69	30.27

	FUD	Status	MUE	Modifiers				IOM Reference
30545	90	A	1(2)	51	N/A	N/A	80	None

* with documentation

Terms To Know

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

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

choanal atresia. Congenital, membranous, or bony closure of one (unilateral) or both (bilateral) posterior nostrils due to failure of the embryonic bucconasal membrane to rupture and open up the nasal passageway causing difficulty breathing. Bilateral choanal atresia is considered a life-threatening emergency because newborns only breathe through their noses and any blocked passages seriously impact breathing; this condition typically presents shortly after birth. Unilateral choanal atresia is often seen in older children and is considered more typical and less concerning since the child is able to breathe and is only impacted on one side of the nasal passage.

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

hard palate. Bony portion of the roof of the mouth.

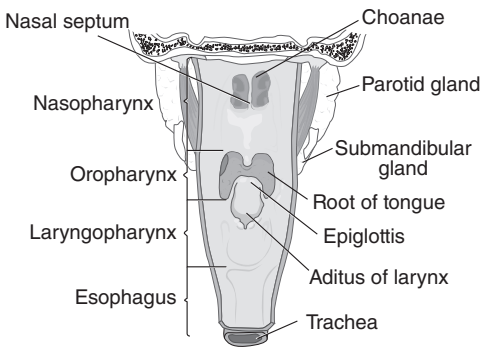
nasal polyp. Fleshy outgrowth projecting from the mucous membrane of the nose or nasal sinus cavity that may obstruct ventilation or affect the sense of smell.

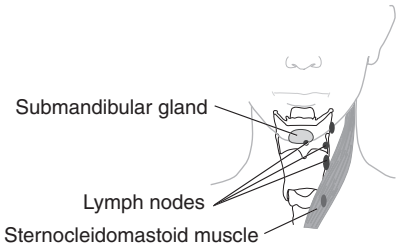
patency. State of a tube-like structure or conduit being open and unobstructed.

transpalatine. Through the roof of the mouth.

31390

31390 Pharyngolaryngectomy, with radical neck dissection; without reconstruction





Explanation

The physician removes the larynx and pharynx. First, a tracheostomy is performed. The physician approaches the pharynx and larynx through a horizontal neck incision. The epiglottis, false vocal cords, mucosal lining of the ventricles, part or all of the hyoid bone, pharynx, and superior part of the laryngeal cartilage are removed. Extensive dissection may include removal of the sternocleidomastoid muscle, the submandibular salivary gland, the internal jugular vein and the lymph nodes of the lateral neck, under the chin and mandible, and the supraclavicular nodes. When either excision is completed, the incision is sutured in layers.

Coding Tips

When reconstruction is performed with pharyngolaryngectomy, with radical neck dissection, see 31395. If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report.

ICD-10-CM Diagnostic Codes

C10.2 Malignant neoplasm of lateral wall of oropharynx
C10.3 Malignant neoplasm of posterior wall of oropharynx
C10.4 Malignant neoplasm of branchial cleft
C10.8 Malignant neoplasm of overlapping sites of oropharynx
C11.0 Malignant neoplasm of superior wall of nasopharynx
C11.1 Malignant neoplasm of posterior wall of nasopharynx
C11.2 Malignant neoplasm of lateral wall of nasopharynx
C11.3 Malignant neoplasm of anterior wall of nasopharynx
C11.8 Malignant neoplasm of overlapping sites of nasopharynx
C12 Malignant neoplasm of pyriform sinus
C13.0 Malignant neoplasm of postcricoid region
C13.1 Malignant neoplasm of aryepiglottic fold, hypopharyngeal aspect
C13.2 Malignant neoplasm of posterior wall of hypopharynx
C13.8 Malignant neoplasm of overlapping sites of hypopharynx
C14.2 Malignant neoplasm of Waldeyer's ring
C14.8 Malignant neoplasm of overlapping sites of lip, oral cavity and pharynx
C15.3 Malignant neoplasm of upper third of esophagus
C15.8 Malignant neoplasm of overlapping sites of esophagus
C32.0 Malignant neoplasm of glottis
C32.1 Malignant neoplasm of supraglottis
C32.2 Malignant neoplasm of subglottis
C32.3 Malignant neoplasm of laryngeal cartilage
C32.8 Malignant neoplasm of overlapping sites of larynx
C78.39 Secondary malignant neoplasm of other respiratory organs
C79.89 Secondary malignant neoplasm of other specified sites
D00.08 Carcinoma in situ of pharynx
D02.0 Carcinoma in situ of larynx
D37.05 Neoplasm of uncertain behavior of pharynx
D38.0 Neoplasm of uncertain behavior of larynx
D49.1 Neoplasm of unspecified behavior of respiratory system

AMA: **31390** 2020,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
31390	42.51	35.12	6.2	83.83
Facility RVU	**Work**	**PE**	**MP**	**Total**
31390	42.51	35.12	6.2	83.83

	FUD	Status	MUE	Modifiers				IOM Reference
31390	90	A	1(2)	51	N/A	62*	80	None

* with documentation

Terms To Know

radical resection. Removal of an entire tumor (e.g., malignant neoplasm) along with a large area of surrounding tissue, including adjacent lymph nodes that may have been infiltrated.

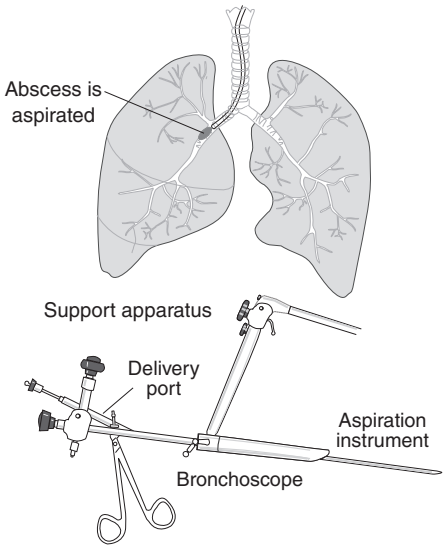
reconstruction. Recreating, restoring, or rebuilding a body part or organ.

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

31645-31646

31645 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, initial

31646 with therapeutic aspiration of tracheobronchial tree, subsequent



Explanation

The physician views the airway using a bronchoscope introduced under appropriate anesthesia through the nasal or oral cavity. The physician uses the views obtained through the bronchoscope to identify the closest approach to the fluid collection from within the airway. The physician may use fluoroscopy (x-ray) to assist with navigation of the bronchoscope tip to the fluid collection. The physician passes a catheter through a channel in the bronchoscope and aspirates the tracheobronchial tree. Alternately, the physician passes a needle through a channel in the bronchoscope into the fluid collection and aspirates fluid through the needle. The bronchoscope is removed. Report 31645 for the initial treatment only. Report 31646 for any subsequent aspiration procedures performed during the same hospital stay. These codes include the use of fluoroscopic guidance, when performed.

Coding Tips

When medically necessary, report moderate (conscious) sedation provided by the performing physician with 99151-99153. When provided by another physician, report 99155-99157. Report the appropriate endoscopy for each anatomic site examined. Surgical bronchoscopy includes a diagnostic bronchoscopy; however, diagnostic bronchoscopy can be identified separately when performed at the same surgical session as an open procedure. Fluoroscopic guidance is not reported separately. For catheter aspiration with fiberscope of the tracheobronchial tree at bedside, see 31725.

ICD-10-CM Diagnostic Codes

A06.5	Amebic lung abscess
A22.1	Pulmonary anthrax
A37.01	Whooping cough due to Bordetella pertussis with pneumonia
B25.0	Cytomegaloviral pneumonitis
E84.0	Cystic fibrosis with pulmonary manifestations
J12.1	Respiratory syncytial virus pneumonia
J12.2	Parainfluenza virus pneumonia
J12.81	Pneumonia due to SARS-associated coronavirus
J14	Pneumonia due to Hemophilus influenzae
J15.0	Pneumonia due to Klebsiella pneumoniae
J15.1	Pneumonia due to Pseudomonas
J15.212	Pneumonia due to Methicillin resistant Staphylococcus aureus
J15.3	Pneumonia due to streptococcus, group B
J15.61	Pneumonia due to Acinetobacter baumannii
J41.0	Simple chronic bronchitis
J43.1	Panlobular emphysema
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J47.0	Bronchiectasis with acute lower respiratory infection
J85.1	Abscess of lung with pneumonia
J85.3	Abscess of mediastinum
J95.851	Ventilator associated pneumonia
J98.11	Atelectasis

AMA: **31645** 2023,Jun; 2021,Apr **31646** 2023,Jun; 2021,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
31645	2.88	5.04	0.29	8.21
31646	2.78	1.12	0.27	4.17
Facility RVU	**Work**	**PE**	**MP**	**Total**
31645	2.88	1.15	0.29	4.32
31646	2.78	1.12	0.27	4.17

	FUD	Status	MUE	Modifiers				IOM Reference
31645	0	A	1(2)	51	N/A	N/A	N/A	None
31646	0	A	2(3)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.

aspirate. To withdraw fluid or air from a body cavity by suction.

bronchoscopy. Endoscopic procedure used for the diagnosis, inspection, and treatment of the tracheobronchial tree.

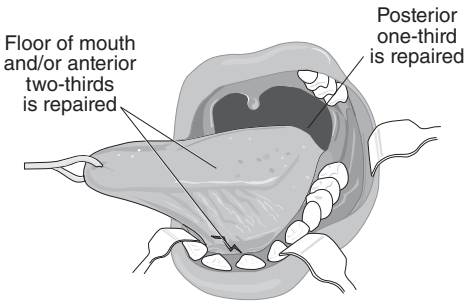
fistula. Abnormal tube-like passage between two body cavities or organs or from an organ to the outside surface.

whooping cough. Acute, highly contagious respiratory tract infection caused by Bordetella pertussis and B. bronchiseptica. Whooping cough is known by its characteristic paroxysmal cough.

41250-41251

41250 Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue

41251 posterior one-third of tongue



Explanation

The physician sutures a laceration measuring 2.5 cm or less of the mouth floor and/or anterior two-thirds of the tongue in 41250 or a laceration in the posterior one-third of the tongue in 41251. This is done simply without tissue rearrangement.

Coding Tips

For repair of a laceration of the tongue, floor of mouth, more than 2.6 cm, see 41252.

ICD-10-CM Diagnostic Codes

K14.0	Glossitis
S00.512A	Abrasion of oral cavity, initial encounter
S00.552A	Superficial foreign body of oral cavity, initial encounter
S01.512A	Laceration without foreign body of oral cavity, initial encounter
S01.522A	Laceration with foreign body of oral cavity, initial encounter
S01.532A	Puncture wound without foreign body of oral cavity, initial encounter
S01.542A	Puncture wound with foreign body of oral cavity, initial encounter
S01.552A	Open bite of oral cavity, initial encounter
S07.0XXA	Crushing injury of face, initial encounter

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
41250	1.96	6.19	0.38	8.53
41251	2.32	6.62	0.49	9.43
Facility RVU	**Work**	**PE**	**MP**	**Total**
41250	1.96	2.3	0.38	4.64
41251	2.32	2.73	0.49	5.54

	FUD	Status	MUE	Modifiers				IOM Reference
41250	10	A	2(3)	51	N/A	N/A	80*	None
41251	10	A	2(3)	51	N/A	N/A	80*	

* with documentation

41252

41252 Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex

Anterior (front) two-thirds of tongue comprises most of the easily visible portions

Explanation

The physician sutures a laceration of the mouth floor or portion of the tongue measuring 2.6 cm or more or requiring complex closure techniques. These may include tissue rearrangement, extensive submucosal suturing, debridement of grossly contaminated lacerations, or repair of through-and-through lacerations.

Coding Tips

Local anesthesia is included in this service. However, this procedure may be performed under general anesthesia, depending on the age and/or condition of the patient. For repair of laceration of the floor of the mouth and/or tongue, 2.5 cm or less, see 41250–41251.

ICD-10-CM Diagnostic Codes

K14.0	Glossitis
S00.512A	Abrasion of oral cavity, initial encounter
S00.522A	Blister (nonthermal) of oral cavity, initial encounter
S00.552A	Superficial foreign body of oral cavity, initial encounter
S01.512A	Laceration without foreign body of oral cavity, initial encounter
S01.522A	Laceration with foreign body of oral cavity, initial encounter
S01.532A	Puncture wound without foreign body of oral cavity, initial encounter
S01.542A	Puncture wound with foreign body of oral cavity, initial encounter
S01.552A	Open bite of oral cavity, initial encounter
S07.0XXA	Crushing injury of face, initial encounter

Relative Value Units/Medicare Edits

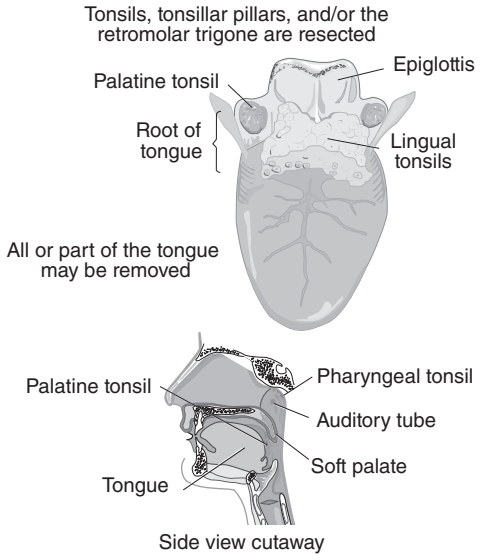
Non-Facility RVU	Work	PE	MP	Total
41252	3.02	6.3	0.5	9.82
Facility RVU	**Work**	**PE**	**MP**	**Total**
41252	3.02	2.77	0.5	6.29

	FUD	Status	MUE	Modifiers				IOM Reference
41252	10	A	2(3)	51	N/A	N/A	80*	None

* with documentation

42842-42845

42842 Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure
42844 closure with local flap (eg, tongue, buccal)
42845 closure with other flap



Explanation

The physician removes the tonsils, tonsillar pillars, and/or the retromolar trigone, along with any affected area of the maxilla or mandible involved in the tumor. First, the physician performs a tracheostomy. The involved tissue is resected. In addition to the above areas, radical resection may include a hemiglossectomy or a total glossectomy, as well as a full neck dissection. In 42842, the wound is so extensive that it is packed open and grafted at a later session. In 42844, the wound is less extensive and can be closed primarily with sutured layers. In 42845, a flap is rotated from the chest. If the wound included a resection of the mandible or maxilla, a fibular bone graft or a metal plate may be used to reconstruct the jaw.

Coding Tips

For closure with other flaps, report the appropriate number for flaps. When combined with radical neck dissection, see 38720. Any bone graft (20900–20902) is reported separately. Because 20900–20902 are subsidiary or "in addition to" codes, modifier 51 is never applied.

ICD-10-CM Diagnostic Codes

C02.4 Malignant neoplasm of lingual tonsil
C05.1 Malignant neoplasm of soft palate
C05.2 Malignant neoplasm of uvula
C06.2 Malignant neoplasm of retromolar area
C09.0 Malignant neoplasm of tonsillar fossa
C09.1 Malignant neoplasm of tonsillar pillar (anterior) (posterior)
C09.8 Malignant neoplasm of overlapping sites of tonsil
C10.0 Malignant neoplasm of vallecula
C10.1 Malignant neoplasm of anterior surface of epiglottis
C10.2 Malignant neoplasm of lateral wall of oropharynx
C10.8 Malignant neoplasm of overlapping sites of oropharynx
C14.8 Malignant neoplasm of overlapping sites of lip, oral cavity and pharynx
D37.09 Neoplasm of uncertain behavior of other specified sites of the oral cavity

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
42842	12.23	16.3	1.82	30.35
42844	17.78	20.93	2.56	41.27
42845	32.56	28.54	4.73	65.83
Facility RVU	**Work**	**PE**	**MP**	**Total**
42842	12.23	16.3	1.82	30.35
42844	17.78	20.93	2.56	41.27
42845	32.56	28.54	4.73	65.83

	FUD	Status	MUE	Modifiers				IOM Reference
42842	90	A	1(3)	51	N/A	N/A	80*	None
42844	90	A	1(3)	51	N/A	62*	80	
42845	90	A	1(3)	51	N/A	62*	80	

* with documentation

Terms To Know

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

epiglottis. Lid-like cartilaginous tissue that covers the entrance to the larynx and blocks food from entering the trachea.

flap. Mass of flesh and skin partially excised from its location but retaining its blood supply that is moved to another site to repair adjacent or distant defects.

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

resection. Surgical removal of a part or all of an organ or body part.

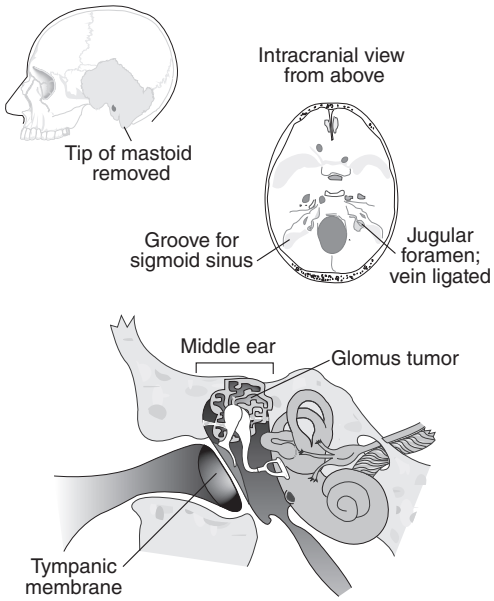
secondary. Second in order of occurrence or importance, or appearing during the course of another disease or condition.

soft palate. Fleshy portion of the roof of the mouth extending from the back of the hard palate and from which the uvula is suspended at the posterior edge.

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

69554

69554 Excision aural glomus tumor; extended (extratemporal)



Explanation

The surgeon makes an incision in front of the ear. The facial nerve, hypoglossal nerve, spinal accessory nerve, internal jugular vein, and carotid artery are identified in the neck. A complete mastoidectomy with extended facial recess is performed. The tip of the mastoid is removed and the jugular bulb is exposed and ligated inferiorly. The mastoid sinus is skeletonized, opened, and packed. Hemostasis is obtained with packing. If the tumor extends intracranially, a craniotomy may be necessary. A parotidectomy may also be needed if further mobilization of the facial nerve is required. The ear canal and ossicles may be removed. The incision is repaired with a layered closure. Dressings are applied.

Coding Tips

For transcanal excision of an aural glomus tumor, see 69550. For transmastoid approach, see 69552.

ICD-10-CM Diagnostic Codes

C75.5	Malignant neoplasm of aortic body and other paraganglia
D14.0	Benign neoplasm of middle ear, nasal cavity and accessory sinuses
D22.21	Melanocytic nevi of right ear and external auricular canal ☑
D22.22	Melanocytic nevi of left ear and external auricular canal ☑
D23.21	Other benign neoplasm of skin of right ear and external auricular canal ☑
D23.22	Other benign neoplasm of skin of left ear and external auricular canal ☑
D44.6	Neoplasm of uncertain behavior of carotid body
D44.7	Neoplasm of uncertain behavior of aortic body and other paraganglia

AMA: **69554** 2023,Apr; 2021,Nov

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
69554	35.97	34.8	5.24	76.01
Facility RVU	**Work**	**PE**	**MP**	**Total**
69554	35.97	34.8	5.24	76.01

	FUD	Status	MUE	Modifiers				IOM Reference
69554	90	A	1(2)	51	50	62*	80	None

* with documentation

Terms To Know

benign. Mild or nonmalignant in nature.

craniotomy. Surgical incision made into the cranium or skull for a number of surgical reasons (e.g., decompression, implantation of electrode array, excision, etc.).

excision. Surgical removal of an organ or tissue.

hemostasis. Interruption of blood flow or the cessation or arrest of bleeding.

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

ossicular chain. Anatomic structure formed by the three small bones of the middle ear - incus, malleus, and stapes - functioning together to conduct sound vibrations through the ear.

vein. Vessel through which oxygen-depleted blood passes back to the heart.

92552-92553

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

Explanation

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

Coding Tips

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

ICD-10-CM Diagnostic Codes

H69.81 Other specified disorders of Eustachian tube, right ear ☑
H69.82 Other specified disorders of Eustachian tube, left ear ☑
H69.83 Other specified disorders of Eustachian tube, bilateral ☑
H83.3X1 Noise effects on right inner ear ☑
H83.3X2 Noise effects on left inner ear ☑
H83.3X3 Noise effects on inner ear, bilateral ☑
H90.0 Conductive hearing loss, bilateral ☑
H90.11 Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side ☑
H90.12 Conductive hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side ☑
H90.3 Sensorineural hearing loss, bilateral ☑
H90.41 Sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side ☑
H90.42 Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side ☑
H90.6 Mixed conductive and sensorineural hearing loss, bilateral ☑
H90.71 Mixed conductive and sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side ☑
H90.72 Mixed conductive and sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side ☑
H90.A11 Conductive hearing loss, unilateral, right ear with restricted hearing on the contralateral side ☑
H90.A12 Conductive hearing loss, unilateral, left ear with restricted hearing on the contralateral side ☑
H90.A21 Sensorineural hearing loss, unilateral, right ear, with restricted hearing on the contralateral side ☑
H90.A22 Sensorineural hearing loss, unilateral, left ear, with restricted hearing on the contralateral side ☑
H90.A31 Mixed conductive and sensorineural hearing loss, unilateral, right ear with restricted hearing on the contralateral side ☑
H90.A32 Mixed conductive and sensorineural hearing loss, unilateral, left ear with restricted hearing on the contralateral side ☑
H91.01 Ototoxic hearing loss, right ear ☑
H91.02 Ototoxic hearing loss, left ear ☑
H91.03 Ototoxic hearing loss, bilateral ☑
H91.11 Presbycusis, right ear ☑
H91.12 Presbycusis, left ear ☑
H91.13 Presbycusis, bilateral ☑
H91.21 Sudden idiopathic hearing loss, right ear ☑
H91.22 Sudden idiopathic hearing loss, left ear ☑
H91.23 Sudden idiopathic hearing loss, bilateral ☑
H93.011 Transient ischemic deafness, right ear ☑
H93.012 Transient ischemic deafness, left ear ☑
H93.013 Transient ischemic deafness, bilateral ☑

AMA: **92553** 2022,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
92552	0.0	1.13	0.01	1.14
92553	0.0	1.37	0.01	1.38
Facility RVU	**Work**	**PE**	**MP**	**Total**
92552	0.0	1.13	0.01	1.14
92553	0.0	1.37	0.01	1.38

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

* with documentation

Terms To Know

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

Correct Coding Initiative Update 32.3

❖Indicates Mutually Exclusive Edit

0208T 36591-36592, 69209-69210, 96523

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

0210T 36591-36592, 69209-69210, 96523

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

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

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

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

0559T 0694T, 76376-76377

0560T 0694T, 76376-76377

0561T 0694T, 76376-76377

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