Optum

Coding Companion

Orthopaedics: Upper-Spine & Above

A comprehensive illustrated guide to coding and reimbursement

2027

optumcoding.com

Contents

Getting Started with Coding Companion

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

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

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to orthopaedics — upper: spine and above are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT/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:

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

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

Abscess
Excision
Olecranon Process, 24138

or **Excision**
Abscess
Olecranon Process, 24138

General Guidelines

Providers

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

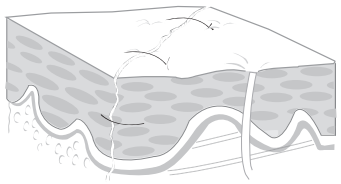
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

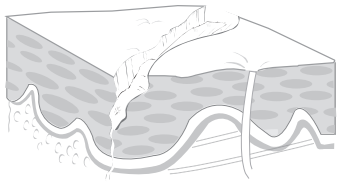
The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

12020-12021

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



Example of a simple closure involving only one skin layer



Example of a wound left open with packing due to infection

Explanation

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

Coding Tips

For extensive or complicated secondary closure of surgical wound or dehiscence, see 13160. Medicare and some other payers may require G0168 be reported for wound closure by tissue adhesives only. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

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

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

Associated HCPCS Codes

G0168 Wound closure utilizing tissue adhesive(s) only

AMA: **12020** 2022,Aug; 2022,Feb; 2021,Aug; 2019,Nov **12021** 2022,Aug; 2022,Feb; 2021,Aug; 2019,Nov

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
12020	2.67	5.94	0.42	9.03
12021	1.89	3.15	0.31	5.35
Facility RVU	**Work**	**PE**	**MP**	**Total**
12020	2.67	2.57	0.42	5.66
12021	1.89	2.05	0.31	4.25

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

* with documentation

Terms To Know

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

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

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

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

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

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

suture. Numerous stitching techniques employed in wound closure.

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

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

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

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

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

1. CPT/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*	

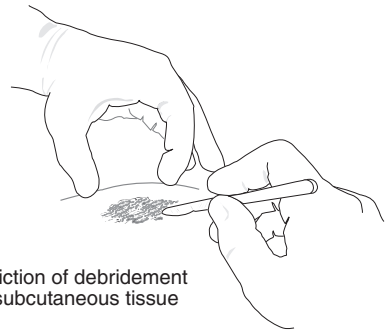
* with documentation

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

11042 [11045]

11042 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less

\+ **11045** Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)



Depiction of debridement of subcutaneous tissue

Explanation

The physician surgically removes foreign matter and contaminated or devitalized subcutaneous tissue (including epidermis and dermis, if performed) caused by injury, infection, wounds (excluding burn wounds), or chronic ulcers. Using a scalpel or dermatome, the physician excises the affected subcutaneous tissue until viable, bleeding tissue is encountered. A topical antibiotic is placed on the wound. A gauze dressing or an occlusive dressing may be placed over the surgical site. Report 11042 for the first 20 sq cm or less and 11045 for each additional 20 sq cm or part thereof.

Coding Tips

Report 11045 in addition to 11042. When reporting debridement of a single wound, the deepest level of tissue removed determines the correct code. The debridement of multiple wounds at the same tissue level may be added together to determine the appropriate code. Different tissue depths should not be added together for code selection. According to the AMA, the debridement of skin (epidermis/dermis) is reported with the codes describing active wound care management (97597 or 97598). Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

L89.011 Pressure ulcer of right elbow, stage 1 ☑
L89.012 Pressure ulcer of right elbow, stage 2 ☑
L89.013 Pressure ulcer of right elbow, stage 3 ☑
L89.111 Pressure ulcer of right upper back, stage 1 ☑
L89.112 Pressure ulcer of right upper back, stage 2 ☑
L89.113 Pressure ulcer of right upper back, stage 3 ☑
L89.131 Pressure ulcer of right lower back, stage 1 ☑
L89.132 Pressure ulcer of right lower back, stage 2 ☑
L89.133 Pressure ulcer of right lower back, stage 3 ☑
L89.151 Pressure ulcer of sacral region, stage 1
L89.152 Pressure ulcer of sacral region, stage 2
L89.153 Pressure ulcer of sacral region, stage 3
L92.8 Other granulomatous disorders of the skin and subcutaneous tissue
L98.491 Non-pressure chronic ulcer of skin of other sites limited to breakdown of skin
T33.41XA Superficial frostbite of right arm, initial encounter ☑
T33.511A Superficial frostbite of right wrist, initial encounter ☑
T33.521A Superficial frostbite of right hand, initial encounter ☑
T33.531A Superficial frostbite of right finger(s), initial encounter ☑

AMA: **11042** 2023,Jun; 2023,Apr; 2022,Aug; 2022,Feb **11045** 2023,Jun; 2023,Apr; 2022,Aug; 2022,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11042	1.01	2.76	0.13	3.9
11045	0.5	0.62	0.08	1.2
Facility RVU	**Work**	**PE**	**MP**	**Total**
11042	1.01	0.67	0.13	1.81
11045	0.5	0.17	0.08	0.75

	FUD	Status	MUE	Modifiers				IOM Reference
11042	0	A	1(2)	51	N/A	N/A	N/A	None
11045	N/A	A	12(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

debridement. Removal of dead or contaminated tissue and foreign matter from a wound.

dermis. Skin layer found under the epidermis that contains a papillary upper layer and the deep reticular layer of collagen, vascular bed, and nerves.

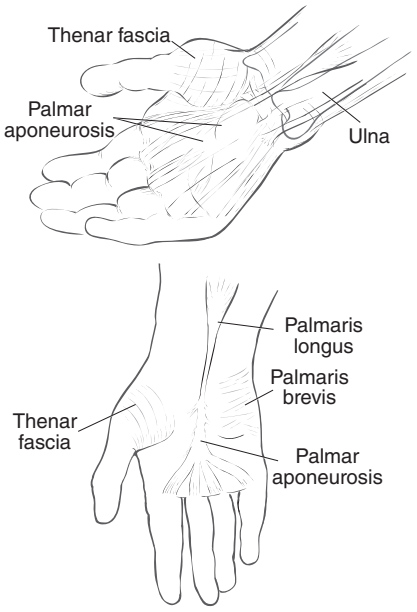
devitalized. Deprivation of vital necessities or of life itself.

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.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 AMA: CPT Assist

20527

20527 Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)



Palmar fascia cord is injected with enzymes

Explanation

This physician corrects connective tissue shortening and thickening in the hand causing "bent finger" or Dupuytren's contracture. Local anesthesia is applied to the hand. An enzyme (clostridial collagenase) is injected directly into the contracted tissues. The enzyme weakens and dissolves the connective tissue in preparation for manipulation to break the connective tissue loose and straighten the finger(s). This procedure is usually followed by separately reportable manipulation a few days after the injection.

Coding Tips

For manipulation of the palmar fascial cord following the enzyme injection, see 26341. For percutaneous palmar fasciotomy, see 26040. For open partial palmar fasciotomy, see 26045.

ICD-10-CM Diagnostic Codes

M72.0 Palmar fascial fibromatosis [Dupuytren] A

Relative Value Units/Medicare Edits

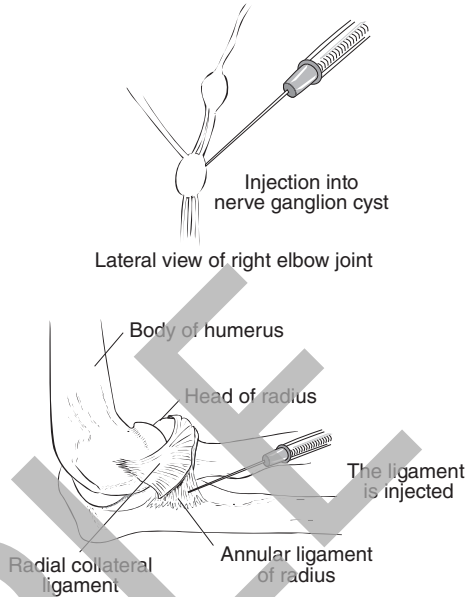
Non-Facility RVU	Work	PE	MP	Total
20527	1.0	1.45	0.19	2.64
Facility RVU	**Work**	**PE**	**MP**	**Total**
20527	1.0	0.78	0.19	1.97

	FUD	Status	MUE	Modifiers				IOM Reference
20527	0	A	2(3)	51	50	N/A	N/A	None

* with documentation

20550

20550 Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")



Explanation

The physician injects a therapeutic agent into a single tendon sheath, or ligament, aponeurosis such as the plantar fascia. The physician identifies the injection site by palpation or radiographs (reported separately) and marks the injection site. The needle is inserted and the medicine is injected. After withdrawing the needle, the patient is monitored for reactions to the therapeutic agent.

Coding Tips

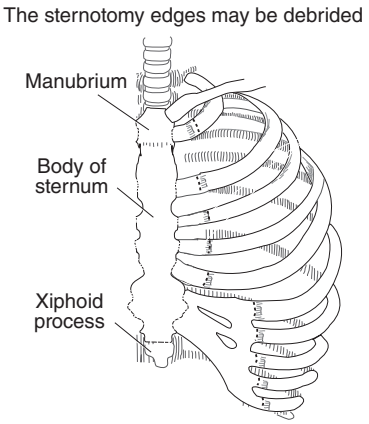
When multiple, separate tendon sheaths are injected in the same encounter, each injection is reported separately. Report 20550 and append modifier 59 or an X{EPSU} modifier for the second and subsequent sites. For injection or aspiration of a ganglion cyst, see 20612. For injection of trigger points, see 20552 and 20553. If imaging guidance is performed, see 76942, 77002, or 77021. Do not report 20550 with 0232T or 0481T. Supplies used when providing this procedure may be reported with the appropriate HCPCS Level II J code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

G89.0 Central pain syndrome
G89.11 Acute pain due to trauma
G89.12 Acute post-thoracotomy pain
G89.21 Chronic pain due to trauma
G89.22 Chronic post-thoracotomy pain
G89.28 Other chronic postprocedural pain
G89.29 Other chronic pain
G89.4 Chronic pain syndrome
M13.111 Monoarthritis, not elsewhere classified, right shoulder ☑
M13.121 Monoarthritis, not elsewhere classified, right elbow ☑
M13.131 Monoarthritis, not elsewhere classified, right wrist ☑
M13.141 Monoarthritis, not elsewhere classified, right hand ☑
M25.511 Pain in right shoulder ☑
M25.521 Pain in right elbow ☑

21750

21750 Closure of median sternotomy separation with or without debridement (separate procedure)



Explanation

The physician performs surgery on the sternum bone to put the bone back together following previous surgical separation. With the patient under anesthesia, the physician makes an incision overlying the sternum. The incision is carried deep to the bone and the separated pieces are identified. The physician debrides soft tissue or bone. The bony fragments are manipulated back together and held in place. The physician uses wire or other internal fixation devices to maintain the bone in the appropriate position. The wound is irrigated and closed in layers.

Coding Tips

This separate procedure by definition is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services, it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append 59 or an X{EPSU}. Sternal debridement is included in this procedure and should not be reported separately. For sternal debridement only, see 21627. When 21750 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.

ICD-10-CM Diagnostic Codes

I97.88	Other intraoperative complications of the circulatory system, not elsewhere classified
I97.89	Other postprocedural complications and disorders of the circulatory system, not elsewhere classified
J95.89	Other postprocedural complications and disorders of respiratory system, not elsewhere classified
T81.89XA	Other complications of procedures, not elsewhere classified, initial encounter

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21750	11.4	6.08	2.71	20.19
Facility RVU	**Work**	**PE**	**MP**	**Total**
21750	11.4	6.08	2.71	20.19

	FUD	Status	MUE	Modifiers				IOM Reference
21750	90	A	1(2)	51	N/A	62*	80	None

* with documentation

Terms To Know

fracture. Break in bone or cartilage.

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.

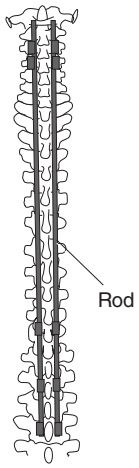
malunion. Fracture that has united in a faulty position due to inadequate reduction of the original fracture, insufficient holding of a previously well-reduced fracture, contracture of the soft tissues, or comminuted or osteoporotic bone causing a slow disintegration of the fracture.

nonunion. Failure of two ends of a fracture to mend or completely heal.

soft tissue. Nonepithelial tissues outside of the skeleton that includes subcutaneous adipose tissue, fibrous tissue, fascia, muscles, blood and lymph vessels, and peripheral nervous system tissue.

22850

22850 Removal of posterior nonsegmental instrumentation (eg, Harrington rod)



Physician removes posterior instrumentation no longer necessary or appropriate

Explanation

Previously applied posterior spinal nonsegmental instrumentation is removed. Instrumentation is sometimes removed when correction is complete and stable, when the patient is a growing juvenile, or when the instrumentation causes complications, such as infection or pain. The patient is placed prone. The physician makes an incision overlying the affected area through the skin, fascia, and paravertebral muscles. Collagen is removed. The instrumentation is exposed and the superior hook or screw is loosened. Using forceps, the upper and lower hooks are disconnected from the vertebra and the hardware is removed.

Coding Tips

When 22850 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. Report exploration of a spinal fusion separately, see 22830. For removal of posterior segmental instrumentation, see 22852. For removal of anterior instrumentation, see 22855. Removal of instrumentation is not reported separately when performed in conjunction with reinsertion. According to CPT guidelines it is inappropriate to append modifier 62 to spinal instrumentation codes.

ICD-10-CM Diagnostic Codes

M96.69	Fracture of other bone following insertion of orthopedic implant, joint prosthesis, or bone plate
T84.216A	Breakdown (mechanical) of internal fixation device of vertebrae, initial encounter
T84.226A	Displacement of internal fixation device of vertebrae, initial encounter
T84.296A	Other mechanical complication of internal fixation device of vertebrae, initial encounter
T84.418A	Breakdown (mechanical) of other internal orthopedic devices, implants and grafts, initial encounter
T84.428A	Displacement of other internal orthopedic devices, implants and grafts, initial encounter
T84.498A	Other mechanical complication of other internal orthopedic devices, implants and grafts, initial encounter
T84.63XA	Infection and inflammatory reaction due to internal fixation device of spine, initial encounter
T84.7XXA	Infection and inflammatory reaction due to other 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
T84.89XA	Other specified complication of internal orthopedic prosthetic devices, implants and grafts, initial encounter
Z47.2	Encounter for removal of internal fixation device

AMA: **22850** 2021,Jul; 2020,May; 2018,Aug

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
22850	9.82	9.59	2.97	22.38
Facility RVU	**Work**	**PE**	**MP**	**Total**
22850	9.82	9.59	2.97	22.38

	FUD	Status	MUE	Modifiers				IOM Reference
22850	90	A	1(2)	51	N/A	62*	80	None

* with documentation

Terms To Know

collagen. Protein based substance of strength and flexibility that is the major component of connective tissue, found in cartilage, bone, tendons, and skin.

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

fascia. Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.

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

instrumentation. Use of a tool for therapeutic reasons.

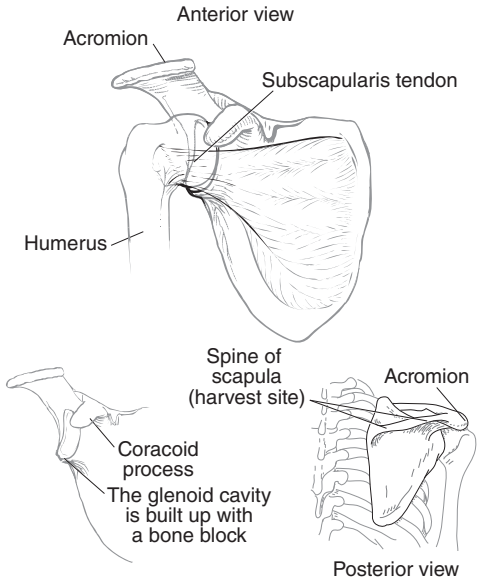
posterior. Located in the back part or caudal end of the body.

prone. Lying face downward.

vertebral column. Thirty-three bones that house the spinal cord, consisting of seven cervical vertebrae, 12 thoracic vertebrae, five lumbar vertebrae, five fused vertebrae in the sacrum, and four fused vertebrae in the coccyx.

23460-23462

23460 Capsulorrhaphy, anterior, any type; with bone block
23462 with coracoid process transfer



Explanation

An anterior capsulorrhaphy of any type with bone block is performed on the shoulder. If there is significant damage to the glenoid where more than one third of the glenoid is deficient, a bone block procedure is performed to increase the surface area of the glenoid. The patient is placed in a lateral position or modified beach chair position. A horizontal or vertical incision is placed inferior to the scapular spine, allowing a bone graft to be taken from the scapular spine if necessary. An additional incision is made at the lateral border of the acromion and carried posteriorly to the axillary crease. The deltoid is split to expose the infraspinatus and teres minor tendons. The capsule is exposed and incised with a T-shaped cut. The capsule is reattached to the glenoid through drill holes or by means of suture anchors taking up slack on the inferior portion of the capsule. The capsular repair may be reinforced using the infraspinatus tendon if the local tissue is felt to be insufficient. The bone block is placed on the posterior inferior portion of the glenoid fossa and fixated with a screw. This bone fragment is usually obtained from the spine of the scapula through a posterior incision. Report 23462 if the procedure is performed with coracoid process transfer.

Coding Tips

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 an anterior capsulorrhaphy, Putti-Platt procedure or Magnuson type, see 23450; for Bankart procedure, see 23455. For capsulorrhaphy of the glenohumeral joint, see 23465 and 23466. For arthroscopic capsulorrhaphy, see 29806. For open thermal capsulorrhaphy, use unlisted procedure code 23929. For arthroscopic thermal capsulorrhaphy, use unlisted procedure code 29999.

ICD-10-CM Diagnostic Codes

M24.311 Pathological dislocation of right shoulder, not elsewhere classified ☑
M24.312 Pathological dislocation of left shoulder, not elsewhere classified ☑
M24.411 Recurrent dislocation, right shoulder ☑
M24.412 Recurrent dislocation, left shoulder ☑
M25.311 Other instability, right shoulder ☑
M25.312 Other instability, left shoulder ☑
S43.011A Anterior subluxation of right humerus, initial encounter ☑
S43.012A Anterior subluxation of left humerus, initial encounter ☑
S43.014A Anterior dislocation of right humerus, initial encounter ☑
S43.015A Anterior dislocation of left humerus, initial encounter ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
23460	15.82	13.86	3.27	32.95
23462	15.72	13.27	3.25	32.24
Facility RVU	**Work**	**PE**	**MP**	**Total**
23460	15.82	13.86	3.27	32.95
23462	15.72	13.27	3.25	32.24

	FUD	Status	MUE	Modifiers				IOM Reference
23460	90	A	1(2)	51	50	62*	80	None
23462	90	A	1(2)	51	50	62*	80	

* with documentation

Terms To Know

anterior. Situated in the front area or toward the belly surface of the body; an anatomical reference point used to show the position and relationship of one body structure to another.

capsulorrhaphy. Suturing or repair of a joint capsule.

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.

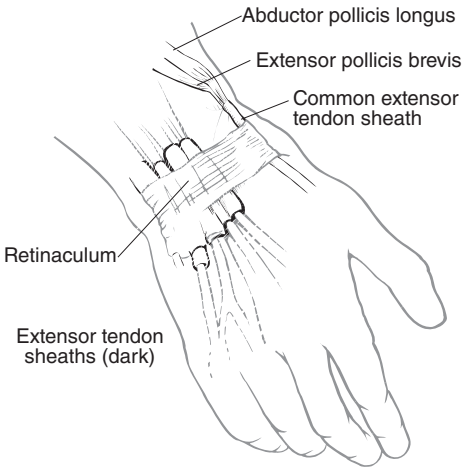
pathological dislocation. Displacement of a bone or joint caused by a disease process, such as infection, lesions, or muscle weakness, and not traumatic injury.

posterior. Located in the back part or caudal end of the body.

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

25000

25000 Incision, extensor tendon sheath, wrist (eg, deQuervains disease)



An extensor tendon sheath is incised

Explanation

The physician incises the extensor tendon sheath over the wrist. The physician incises the skin just proximal to the anatomic snuffbox. The tissues are dissected and the extensor retinaculum of the first extensor compartment is identified and incised. The incision is sutured in layers.

Coding Tips

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 decompression of the median nerve (carpel tunnel syndrome), see 64721.

ICD-10-CM Diagnostic Codes

M12.231 Villonodular synovitis (pigmented), right wrist ☑
M12.232 Villonodular synovitis (pigmented), left wrist ☑
M65.4 Radial styloid tenosynovitis [de Quervain]
M65.841 Other synovitis and tenosynovitis, right hand ☑
M65.842 Other synovitis and tenosynovitis, left hand ☑
M70.031 Crepitant synovitis (acute) (chronic), right wrist ☑
M70.032 Crepitant synovitis (acute) (chronic), left wrist ☑

Relative Value Units/Medicare Edits

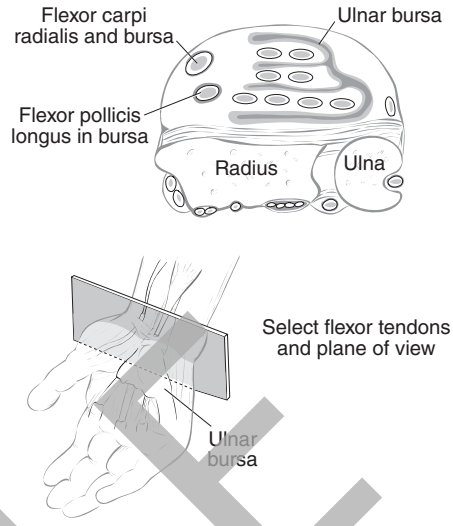
Non-Facility RVU	Work	PE	MP	Total
25000	3.55	6.45	0.68	10.68
Facility RVU	**Work**	**PE**	**MP**	**Total**
25000	3.55	6.45	0.68	10.68

	FUD	Status	MUE	Modifiers				IOM Reference
25000	90	A	2(3)	51	50	N/A	N/A	None

* with documentation

25001

25001 Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)



An incision is made into a flexor tendon sheath

Explanation

The physician incises the flexor tendon sheath over the wrist. The physician makes a radial incision. The tissues are dissected to the tendon sheath. The compartment is identified and incised. When incising the flexor carpi radialis (FCR) the tendon sheath is opened proximal to distal. The fibro-osseous tunnel is released along the ulnar border of the trapezium. The incision is closed with layered suture.

Coding Tips

This is a unilateral procedure. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code, while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image).

ICD-10-CM Diagnostic Codes

M12.231 Villonodular synovitis (pigmented), right wrist ☑
M12.232 Villonodular synovitis (pigmented), left wrist ☑
M65.841 Other synovitis and tenosynovitis, right hand ☑
M65.842 Other synovitis and tenosynovitis, left hand ☑
M70.031 Crepitant synovitis (acute) (chronic), right wrist ☑
M70.032 Crepitant synovitis (acute) (chronic), left wrist ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
25001	3.79	6.22	0.72	10.73
Facility RVU	**Work**	**PE**	**MP**	**Total**
25001	3.79	6.22	0.72	10.73

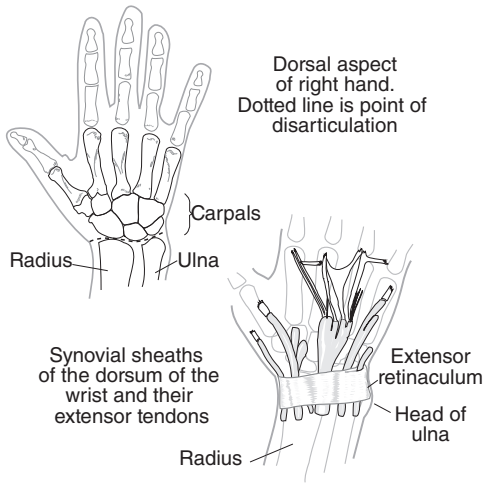
	FUD	Status	MUE	Modifiers				IOM Reference
25001	90	A	1(3)	51	50	N/A	N/A	None

* with documentation

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

25920-25924

25920 Disarticulation through wrist;
25922 secondary closure or scar revision
25924 re-amputation



Explanation

The physician disarticulates (amputates) the hand from the forearm through the wrist. The physician makes a long, palmar flap and a short, dorsal flap at a level distal to the radioulnar joint. These flaps are pulled back proximally and all veins are ligated. The physician cuts the superficial branch of the radial nerve and the dorsal sensory branch of the ulnar nerve. The lateral and medial antebrachial cutaneous nerves are cut. The radial and ulnar blood vessels are severed proximate to the wrist. The median nerve is cut while traction is applied. The flexor and extensor tendons are pulled distally and cut. The physician makes a transverse, dorsal incision of the dorsal radiocarpal ligament to view the radiocarpal joint. Circumferential dissection of the radiocarpal capsular and ligamentous attachments are carried out. The amputated specimen is removed. The styloid processes are rounded off and the skin flaps are closed in two layers of subcutaneous tissue and skin. A soft dressing is applied distal to proximal. Report 25920 if an amputation through the wrist is performed. Report 25922 if a secondary closure or scar revision is performed on the stump. Report 25924 if a re-amputation is performed. All use a similar technique.

Coding Tips

Adjacent tissue transfer is included in these procedures. However, report any free grafts separately.

ICD-10-CM Diagnostic Codes

C40.11 Malignant neoplasm of short bones of right upper limb ☑
C40.12 Malignant neoplasm of short bones of left upper limb ☑
C49.11 Malignant neoplasm of connective and soft tissue of right upper limb, including shoulder ☑
C49.12 Malignant neoplasm of connective and soft tissue of left upper limb, including shoulder ☑
E08.52 Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene
E09.52 Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene
E10.52 Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E11.52 Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E13.52 Other specified diabetes mellitus with diabetic peripheral angiopathy with gangrene
M72.6 Necrotizing fasciitis
M86.341 Chronic multifocal osteomyelitis, right hand ☑
M86.342 Chronic multifocal osteomyelitis, left hand ☑
M86.441 Chronic osteomyelitis with draining sinus, right hand ☑
M86.442 Chronic osteomyelitis with draining sinus, left hand ☑
M87.041 Idiopathic aseptic necrosis of right hand ☑
M87.042 Idiopathic aseptic necrosis of left hand ☑
S67.31XA Crushing injury of right wrist, initial encounter ☑
S67.32XA Crushing injury of left wrist, initial encounter ☑
S67.41XA Crushing injury of right wrist and hand, initial encounter ☑
S67.42XA Crushing injury of left wrist and hand, initial encounter ☑
S68.421A Partial traumatic amputation of right hand at wrist level, initial encounter ☑
S68.422A Partial traumatic amputation of left hand at wrist level, initial encounter ☑
T87.31 Neuroma of amputation stump, right upper extremity ☑
T87.32 Neuroma of amputation stump, left upper extremity ☑
T87.41 Infection of amputation stump, right upper extremity ☑
T87.42 Infection of amputation stump, left upper extremity ☑
T87.51 Necrosis of amputation stump, right upper extremity ☑
T87.52 Necrosis of amputation stump, left upper extremity ☑
T87.81 Dehiscence of amputation stump
Z48.1 Encounter for planned postprocedural wound closure
Z89.111 Acquired absence of right hand ☑
Z89.112 Acquired absence of left hand ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
25920	9.03	11.33	1.85	22.21
25922	7.65	10.48	1.58	19.71
25924	8.81	11.08	1.81	21.7
Facility RVU	**Work**	**PE**	**MP**	**Total**
25920	9.03	11.33	1.85	22.21
25922	7.65	10.48	1.58	19.71
25924	8.81	11.08	1.81	21.7

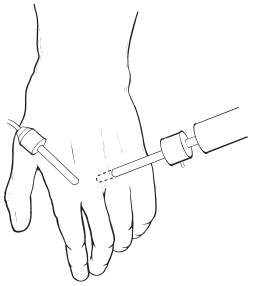
	FUD	Status	MUE	Modifiers				IOM Reference
25920	90	A	1(2)	51	50	N/A	80*	None
25922	90	A	1(2)	51	50	N/A	80	
25924	90	A	1(2)	51	50	N/A	80	

* with documentation

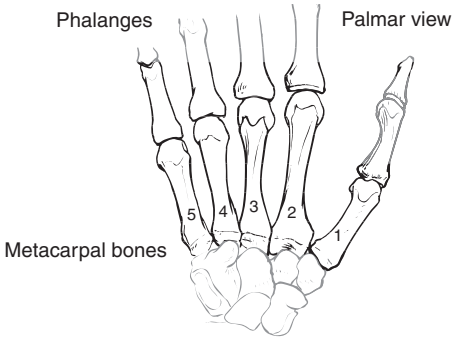
● New ▲ Revised + Add On ★ Telemedicine [Resequenced] ☑ Laterality

29900

29900 Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy



The metacarpophalangeal joint is scoped for diagnostic purposes. A biopsy of the synovium may be collected



Explanation

The metacarpophalangeal joints consist of the convex heads of the metacarpals articulating with the concave bases of the proximal phalanges. The metacarpophalangeal joint of interest is placed for easy access and an injection of local anesthetic is administered. Incisions for portals are made in the respective metacarpal to allow the arthroscope and surgical instruments to be introduced into the joint. The arthroscope is inserted through a portal into the joint, and the surgical equipment is passed through a second portal. A third portal may have been made for pumping fluid in to expand the joint space for clearer visualization. A needle is inserted through the trocar and twisted to cut out the tissue segment for biopsy. The biopsy needle, trocar, and arthroscope are removed. The site is cleansed and a pressure bandage is applied.

Coding Tips

Do not report 29900 with 29901 or 29902. Some payers may require the use of HCPCS Level II modifiers FA–F9 to identify the specific finger involved. When 29900 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. When arthroscopy is performed in conjunction with arthrotomy, add modifier 51. Surgical arthroscopy always includes diagnostic arthroscopy. Local anesthesia is included in this service.

ICD-10-CM Diagnostic Codes

M06.4 Inflammatory polyarthropathy
M12.141 Kaschin-Beck disease, right hand ☑
M12.142 Kaschin-Beck disease, left hand ☑
M12.241 Villonodular synovitis (pigmented), right hand ☑
M12.242 Villonodular synovitis (pigmented), left hand ☑
M24.841 Other specific joint derangements of right hand, not elsewhere classified ☑
M24.842 Other specific joint derangements of left hand, not elsewhere classified ☑
M60.241 Foreign body granuloma of soft tissue, not elsewhere classified, right hand ☑
M60.242 Foreign body granuloma of soft tissue, not elsewhere classified, left hand ☑
M62.89 Other specified disorders of muscle
M65.841 Other synovitis and tenosynovitis, right hand ☑
M65.842 Other synovitis and tenosynovitis, left hand ☑
M72.8 Other fibroblastic disorders
M86.141 Other acute osteomyelitis, right hand ☑
M86.142 Other acute osteomyelitis, left hand ☑
M86.441 Chronic osteomyelitis with draining sinus, right hand ☑
M86.442 Chronic osteomyelitis with draining sinus, left hand ☑
M86.8X4 Other osteomyelitis, hand
M89.741 Major osseous defect, right hand ☑
M89.742 Major osseous defect, left hand ☑
M89.78 Major osseous defect, other site
M89.79 Major osseous defect, multiple sites
M90.841 Osteopathy in diseases classified elsewhere, right hand ☑
M90.842 Osteopathy in diseases classified elsewhere, left hand ☑
S61.421A Laceration with foreign body of right hand, initial encounter ☑
S61.422A Laceration with foreign body of left hand, initial encounter ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
29900	5.88	8.37	1.22	15.47
Facility RVU	**Work**	**PE**	**MP**	**Total**
29900	5.88	8.37	1.22	15.47

	FUD	Status	MUE	Modifiers				IOM Reference
29900	90	A	2(3)	51	50	N/A	80*	None

* with documentation

Correct Coding Initiative Update 32.3

❖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

0095T 36591-36592, 38220, 38222, 38230, 38232, 63707, 63709, 96523, 99446-99449, 99451-99452

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