Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

Early Childhood Intervention

Updated 04.2025

PART II
EARLY CHILDHOOD INTERVENTION
FEE-FOR-SERVICE PROVIDER MANUAL

Introduction

FORMS All forms pertaining to this provider manual can be found on the public website and on the secure website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare managed care organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

PART II
EARLY CHILDHOOD INTERVENTION
FEE-FOR-SERVICE PROVIDER MANUAL

Updated 01/18

This is the provider specific section of the manual. This section (Part II) was designed to provide information and instructions specific to Early Childhood Intervention (ECI) providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendix.

The **Billing Instructions** subsection explains the method of billing applicable to ECI services.

The **Benefits and Limitations** subsection defines specific aspects of the scope of ECI services allowed within Kansas Medical Assistance Program (KMAP).

The **Appendix** subsection contains information concerning codes. The appendix was developed to make finding and using codes easier for the biller.

Access to Records
Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. The provider agrees to furnish records and original radiographs and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP consumers. If the required records are retained on machine readable media, a hard copy of the records must be made available.

The provider agrees to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

Confidentiality & HIPAA Compliance
Providers shall follow all applicable state and federal laws and regulations related to confidentiality as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164.

BILLING INSTRUCTIONS

7000. EARLY CHILDHOOD INTERVENTION BILLING INSTRUCTIONS Updated 01/18

Introduction to the CMS 1500 Claim Form

Early childhood intervention providers must use the CMS 1500 paper or equivalent electronic claim form when requesting payment for medical services and supplies provided under KMAP. Claims can be submitted on the KMAP secure website, through Provider Electronic Solutions (PES), or by paper. When a paper form is required, it must be submitted on an original, red claim form and completed as indicated.

An example of the CMS 1500 Claim Form and instructions are available on the public and the secure websites under the Publications tab on the Forms page under the Claims (Sample Forms and Instructions) heading.

The Kansas MMIS will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

Any of the following billing errors may cause a CMS 1500 Claim Form to deny or be sent back to the provider:

- Sending a KanCare paper claim to KMAP.
- Sending a CMS 1500 claim form carbon copy.
- Using a PO Box in the Service Facility Location Information field.

The fiscal agent does not furnish the CMS 1500 Claim Form to providers.

Submission of Claim

Send completed claim and any necessary attachments to:

Office of the Fiscal Agent
PO Box 3571
Topeka, Kansas 66601-3571

BENEFITS AND LIMITATIONS

8100. COPAYMENT Updated 01/18

ECI services are exempt from copayment requirements.

BENEFITS AND LIMITATIONS

8300. BENEFIT PLAN Updated 01/18

KMAP members will be assigned to one or more benefit plans. These benefit plans entitle the member to certain services. If there are questions about service coverage for a given benefit plan, refer to **Section 2000** of the *General Benefits Fee-for-Service Provider Manual* for information on eligibility verification.

BENEFITS AND LIMITATIONS

8400. MEDICAID Updated 10/21

The ECI (also known as Part C) program provides early intervention services to children from birth to three years of age who meet one of the developmental delay eligibility categories. Part C (formerly Part H) is part of the Individuals with Disabilities Education Act (IDEA).

To enroll as a provider of ECI, you must be a local early intervention program designated by the Kansas Department of Health and Environment (KDHE) or submit a document signed by the local early intervention program certifying that you are a Part C provider and meet the federal requirements to provide services. All Part C providers must follow the Primary Services Provider Coaching Model that is fully detailed in the State Part C Procedure Manual. Therefore, Medicaid billing will coincide with the services provided in the Primary Services Provider Coaching Model as outlined in the State Part C Procedure Manual.

Certain codes listed in the appendix are "FFP only" (just the federal share). On a quarterly basis, KDHE Division of Health Care Finance (DHCF) sends to KDHE Bureau of Family Health (BFH) a certified match certification letter and a copy of the MMIS certification report. This report documents, in summary form, the dollar amounts of the claims paid to the provider during the previous quarter. The report shows the federal amount received by the provider and the required contribution of state match funds. KDHE-BFH completes the certification letter and returns it to KDHE-DHCF.

ECI services do not require a referral from the child's managed care provider (PCCM or HMO); however, a physician-selected ICD diagnosis code must identify the specific condition for which the member is receiving services (i.e. a diagnosis of mental retardation is inappropriate to use when billing for audiological services).

Therapy codes may be billed only for individuals with a physician treatment plan, an individualized education plan (IEP), or an individualized family service plan (IFSP) (refer to Appendix I). A physician's order is required for physical, speech, occupational, and other therapies. A physician’s order is not required for initial evaluations to determine eligibility.

Services must be medically necessary and may be habilitative or rehabilitative for maximum reduction of disability to the best possible functional level.

Therapy is covered for any birth defects/developmental delays only when approved and provided by an ECI, Head Start, or Local Education Agency (LEA) program. Therapy of this type is covered only for participants aged 0 to under the age of 21. Services which are educationally necessary but not medically necessary are not covered.

Therapy codes must be billed as one unit equals one visit unless the description of the code specifies the unit.

8400. MEDICAID Updated 05/24

Documentation of all services performed is required and must include:

- Date, time, and description of each service delivered and by who (name, designation of profession or paraprofession)
- Assessment and response to intervention/service
- Progress toward achieving individualized long- and short-term goals

Co-treatment consists of more than one professional providing treatment at the same time. Therapists or therapist assistants working together as a "team" to treat one or more individuals **cannot** bill separately for the same or different services provided at the same time to the same individual. For cotreatments, only one *CPT* code may be billed per session (untimed *CPT* codes) or per unit (timed *CPT* codes). Either one therapist can bill for the entire service, or the therapists can divide the service units (if applicable) where an occupational and physical therapist (timed *CPT* code) both provide services to one individual at the same time. Only one discipline per session may be billed where an SLP (untimed *CPT* code) and an occupational or physical therapist (timed *CPT* code) both provide services to one individual at the same time.

However, Family Service Coordination (T1017) and Developmental Intervention Services (T1027) provided by a different provider at the same patient interaction are allowed to be billed. For example, if two providers conduct a joint visit and the Primary Service Provider is providing the family with information, skills and support related to enhancing the skill development of the child (Developmental Intervention Services T1027) and the Secondary Service Provider is providing a therapy service (timed CPT) code at the same time, both can be billed during the same service time.

The Kansas Medicaid Fraud Control Act, K.S.A. 2004 Supp. 21-3844 to 21-3855, requires that providers keep records for five years from the date of payment or, if the claim does not pay, the date when the provider submitted the claim:

"Upon submitting a claim for or upon receiving payment for goods, services, items, facilities, or accommodations under the Medicaid program, a person shall maintain adequate records for five years after the date on which payment was received, if payment was received, or for five years after the date on which the claim was submitted, if the payment was not received" (K.S.A. 21-3848).

Services provided by ECI providers to children eligible for Part C of the IDEA are by law at no cost to the family. Because the services are provided at no charge to the family, most insurance companies consider these services not covered by their policies. Therefore, KDHE does not require ECI providers to seek payment from private insurance companies to be eligible to receive Medicaid reimbursement. Similarly, KDHE will not seek reimbursement from the insurance companies.

However, KDHE does require all Medicaid providers to report insurance resources of which they become aware. This reporting assists KDHE in billing for other services which the other insurance company does cover, such as hospitalization.

This policy does not prevent ECI providers from billing and collecting from insurance companies which do cover these services. If a provider anticipates that an insurance company will cover the services and the parents give the provider permission to bill the insurance, this private resource should be accessed prior to accessing taxpayer-funded Medicaid.

8400. MEDICAID Updated 04/25

TELEMEDICINE

Refer to **Section 2720** of the *General Benefits Fee-for-Service Provider Manual* for complete details regarding Telemedicine.

FAMILY SERVICE COORDINATION

ECI local programs can provide and bill Family Service Coordination for children less than four years old. Services are not covered for children who receive case management under any other Medicaid service coordination option, such as Home and Community Based Services, attendant care for independent living (ACIL), or Children and Family Services contracts.

Family Service Coordination means the activities carried out to assist and enable a child eligible under Part C of the IDEA and the child's family to receive the rights, procedural safeguards, and services that are authorized to be provided through Kansas Infant-Toddler Services. The family service coordinator is responsible for coordinating all services across agency lines and serving as a single point of contact in helping parents to obtain the services and assistance they need.

Family Service Coordination is an active, ongoing process that involves:

- Assisting families of eligible children in gaining access to early intervention services and other services identified in the IFSP
- Coordinating the provision of early intervention services and other services (such as medical services for other than diagnostic and evaluation purposes) that the child needs or is being provided
- Facilitating the timely delivery of available services
- Continuously seeking the appropriate services and situations necessary to benefit the development of each child being served for the duration of the child's eligibility

Specific family service coordination activities include:

- Coordinating the performance of evaluations and assessments
- Facilitating and participating in the development, review, and evaluation of IFSPs
- Assisting families in identifying available service providers
- Coordinating and monitoring the delivery of available services
- Informing families of the availability of advocacy services
- Coordinating with medical and health providers
- Facilitating the development of a transition plan to preschool services, if appropriate
- Maintaining a record of case management activities in each child’s record (34 CFR 303.22)

Benefits

The following are general activities which can be billed to Medicaid as family service coordination activities:

- **Intake** such as: compiling or completing enrollment packets; conducting family interviews and sharing information; providing or receiving referral information; reviewing the IFSP process and service delivery system with the family.
- **Service planning** such as: identifying the child's medical, social, and early intervention needs; consulting with other providers and the child's family; requesting records; coordinating the evaluation and assessment process; facilitating formation of an IFSP team based on the child's presenting needs; facilitating the development of the IFSP.

FAMILY SERVICE COORDINATION continued

- **Service coordination** such as: providing and/or sharing information about community services and resources, referral for community services; following up on referrals; ensuring the IFSP is implemented and assessing the child's progress toward meeting outcomes; facilitating periodic and annual reviews of the IFSP; evaluating the family's satisfaction with supports and services; coordinating with health and medical services; monitoring the child's health status.
- **Advocacy** such as: providing information regarding the Part C procedural safeguards; coordinating of a child advocate when child is in need of a surrogate parent; providing advocacy on behalf of the child and family to receive community resources; representing the child or family at meetings or hearing.
- **Transition planning** such as: developing a transition plan; arranging transition meetings; conducting transition meetings; arranging for and participating in visits to new services; attending IEP meeting; arranging transition follow-up activities.

Qualifications and Training

Personnel must have the following qualifications to provide family service coordination for children and families eligible for Part C of the IDEA.

The family service coordinator must have demonstrated knowledge and understanding about:

- Infants and toddlers who are eligible under Part C of the IDEA
- Part C of the IDEA and the regulations of this part
- The nature and scope of services available under Kansas' early intervention program, the system of payments for services in Kansas, and other pertinent information [34 CFR 303.22(d)]

Each early intervention local program must ensure family service coordination personnel meet the previous qualifications. This may be accomplished by requiring family service coordinators to demonstrate certain core competencies. Some examples of these competencies can include, but are not limited to:

- Infant and child development
- Family-centered care
- Part C law and regulations
- IFSP process and development
- Advocacy
- Legal issues
- Medical issues
- Service coordination
- Community resources
- Professional development

It is recommended that each family service coordinator participate in at least six hours of training, in any of the previous areas, each year to remain qualified to receive Medicaid reimbursement for family service coordination activities.

FAMILY SERVICE COORDINATION continued

A qualified early intervention service provider who provides other direct early intervention services (physical therapy, occupational therapy, etc.) may be selected as a qualified family service coordinator. The family service coordinator does not authorize or restrict services. His or her role is to coordinate the implementation of the child's IFSP. The family service coordinator must accept full responsibility to provide all the components of family service coordination to meet the needs of the child/family.

Enrollment

The local early intervention local program will be designated as the Family Service Coordination provider. Family Service Coordination activities may be carried out by qualified personnel through the following options:

- Local programs may employ qualified family service coordinators.
- Local programs may contract with a private agency that employs or contracts with qualified family service coordinators or a qualified individual that participates with the local early intervention system.
- Local programs may establish interagency agreements with other public agencies that employ or contract with qualified family service coordinators.
- The early intervention local programs are responsible to ensure personnel providing family service coordination are qualified.

Monitoring

Each early intervention local program must ensure personnel meet these qualifications. K.A.R. 28-4-556 requires that "Family Service Coordinators shall be monitored to determine if they are meeting the individualized needs of children and families." In addition, the KDHE *Procedure Manual for Infant-Toddler Services in Kansas* (Section XVIII-5) requires that the early intervention local program develop a self-evaluation/monitoring plan which must include:

- An annual evaluation of the effectiveness of family service coordination
- Assurance that family service coordination is consistent with Part C of the IDEA

Documentation

The family service coordinator must maintain a record of the child/family he or she provides services to which shows the following:

- The name of the child receiving the service
- The date the service was provided
- The name of the provider agency
- The name of the family service coordinator providing the service
- The location in which the service was provided
- The type of family service coordination service provided as described in family service coordination benefits
- The amount of time it was provided to the nearest quarter of an hour

Freedom of Choice

The family has the right to choose their qualified family service coordinator. The child/family has the right to request a different family service coordinator.

FAMILY SERVICE COORDINATION continued

Code

Use code T1017 and Provider Type and Provider Specialty (PT/PS) 21/186 for billing ECI Family Service Coordination. This service must be billed by units or partial units of service as outlined below:

- 0.5 units = 0.1 through 7.5 minutes of ECI Family Service Coordination
- 1 unit = 7.51 through 15 minutes of ECI Family Service Coordination

Approved Place of Service (POS) Codes:

- 02 (Telehealth Provided Other than in Patients Home)
- 03 (School)
- 04 (Homeless Shelter)
- 10 (Telehealth Provided in Patients Home)
- 11 (Office)
- 12 (Home)
- 20 (Urgent Care Facility)
- 27 (Non-permanent Location (homeless)
- 99 (Other Place of Service)

DEVELOPMENTAL INTERVENTION SERVICES

Developmental Intervention Services is for all children in the Part C program and a billable service for all visits. ECI programs are allowed to bill for Developmental Intervention Services. Services include activities that promote the child's functional independence through acquisition of daily living, social-emotional, and cognitive skills.

- Information and skills training to the family to enable them to enhance the health and development of the child
- Initial evaluation to determine eligibility
- On-going assessment of the child's developmental status, if ECI eligible
- Re-evaluation, as necessary, of ECI-eligible children

Covered services include only those services referred by an IFSP team and included on an IFSP, or in determination of eligibility for Part C of IDEA services.
Examples of billable activities include:

- Providing an initial evaluation to determine eligibility
- Providing an on-going assessment of the child's overall development, if ECI eligible
- Re-evaluation, as necessary, of ECI-eligible children
- Providing families with information, skills, and support related to enhancing the skill development of the child
- Working with the child to enhance the child's development

Qualifications

Professionals providing developmental intervention services must meet the early intervention provider qualification standards, as outlined in the KDHE *Procedure Manual for Infant-Toddler Services in Kansas*.

8400. MEDICAID Updated 01/21

DEVELOPMENTAL INTERVENTION SERVICES continued

Procedure Code

Use procedure code T1027 for billing developmental intervention services. This service must be billed by units or partial units of service as outlined below:

- 0.5 units = 0.1 through 7.5 minutes of ECI developmental intervention services
- 1 unit = 7.51 through 15 minutes of ECI developmental intervention services

Note: Only those services in which the child is present are billable units of service.

Services delivered in group settings must be billed at the same total rate as this service delivered to an individual, divided by the number of members in the group receiving service. Providers will be required to maintain records of all Medicaid-eligible and non-Medicaid-eligible participants in the group to facilitate confirmation of appropriate billing.

KDHE is certifying the nonfederal match necessary to access federal funds for this service. To ensure that the available state funds are not overextended, it was determined to reimburse only the programs contracted with KDHE for this service.

The programs may subcontract with other agencies or provide developmental intervention services with in-house staff. However, the local program will be required to file for reimbursement.

TRANSPORTATION SERVICES

ECI providers must go through the KanCare subcontractor providers for Kansas Medicaid nonemergency medical transportation (NEMT). Currently, they are:

- Sunflower: LogistiCare
- UnitedHealthcare: LogistiCare
- Aetna: Access2Care

REPLACEMENT HEARING AID SERVICES

All hearing aid replacements will require the use of modifier RA. Modifier RA must be present on all claims for replacement hearing aids. Replacement hearing aids will continue to require PA. Refer to **Section 8400** of the *Audiology Fee-for-Service Provider Manual* for additional information.

MATERNAL DEPRESSION SCREENINGS

Maternal Depression screenings are reimbursable for Early Child Intervention services using the Current Procedural Technology (CPT) and HCPCS codes 96161, G8431 and G8510 when using one or more of the following validated screening tools:

- Edinburgh Postnatal Depression Scale (EPDS)
- Postpartum Depression Screening Scale (PDSS)
- Patient Health Questionnaire 9 (PHQ-9)
- Beck Depression Inventory II (BDI-II)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Zung Self-Rating Depression Scale (SDS)

MATERNAL DEPRESSION SCREENINGS continued

Approved PT/PS Code:
08-183 (Clinic-Early Intervention Services)

Approved POS Codes:
11 (Office)
12 (Home)

A screening that occurs after the child is born is considered an Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit per Centers for Medicare and Medicaid Services (CMS) guidance, and should be billed under the infant's Medicaid ID number, using CPT code 96161. If the child does not have an assigned Medicaid ID number, CPT code 96161 can be billed under the mother's Medicaid ID number, for up to 45 days postpartum. The screening CPT code 96161 is reimbursable postpartum, up until the child is 12 months of age.

The Maternal Depression Screenings can be administered by non-licensed staff. This includes home visitors, medical assistants, and community health workers since they are supervised by licensed professionals performing the primary service. These screenings should be reviewed by licensed professionals to ensure accuracy of the scoring and any necessary follow-up.

Referral and Follow-up Process on Positive Screenings Recommended by the American Academy of Pediatrics (AAP):
Immediate action is necessary if:

- Possible suicidality indicated in screening tool
- Mother expresses concern about her or her infant's safety
- Provider suspects that the mother is suicidal, homicidal, severely depressed, manic or psychotic

When a depression screen is positive, management varies according to the degree of concern and need. Management of Postpartum Depression includes:

- Demystification (reducing guilt and shame by emphasizing how common these feelings are)
- Support resources (family and community); and
  Referrals for the mother (to a mental health professional or the mother's primary care provider [PCP] or obstetrician), for the mother-infant dyad, for the child (for targeted promotion of social-
  emotional development and early intervention, and for the mother who is breastfeeding (for lactation support from an experienced provider).

Training Opportunities:
Optional training will be offered to screeners, including medical providers and their clinical staff, to increase timely detection of maternal depression. The Mental Health Integration Toolkit on the KDHE website, will be updated by Public Health and will provide guidance on screening practices and patient and provider resources. There is also a national program, Mental Health First Aid, that teaches the skills to respond to the signs of mental illness and substance use.

APPENDIX

CODES Updated 08/24

The following *Current Procedural Technology (CPT)* codes represent a list of billable Early Childhood Intervention services.

Use the following resources to determine coverage and pricing information. For accuracy, use your PT/PS as well as the member ID number or benefit plan.

- Information is available on the Reference Codes page of the public website.
- Information is available on the secure website under Pricing and Limitations.

Charts have been developed to assist providers in understanding how KMAP will handle specific modifiers. The Coding Modifiers Table and Ambulance Coding Modifiers Table are on the Reference Codes page of the public website and under Pricing and Limitations on the secure portion.

COVERAGE INDICATORS

FFP	=	Federal financial participation
KBH-EPSDT	=	KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment medical participation is required.
MN	=	Medical necessity documentation is required.
PA	=	Procedure requires prior authorization.
PA*	=	Prior authorization required for replacement only.

PLACE OF SERVICE RESTRICTIONS

03	=	School
11	=	Office
12	=	Home
99	=	Other

CASE MANAGEMENT

Coverage	Code		Coverage	Code
FFP	T1017		FFP	T1027

COUNSELING

Coverage	Code		Coverage	Code
FFP, KBH-EPSDT	99401		FFP, KBH-EPSDT	99404
FFP, KBH-EPSDT	99402		FFP, KBH-EPSDT	99411
FFP, KBH-EPSDT	99403		FFP, KBH-EPSDT	99412

DIETITIAN SERVICES

Coverage	Code		Coverage	Code
KBH-EPSDT	97802		KBH-EPSDT	97803

NEUROLOGY AND NEUROMUSCULAR PROCEDURES

Coverage	Code		Coverage	Code
	95831			95834
	95832			95851
	95833			95852

CODES Updated 04/25

PHYSICAL MEDICINE

Coverage	Code		Coverage	Code
	92507			97116
	92508			97124
	96110			97129
	96112			97130
	97010			97140
	97012			97150
	97014			97161
	97018			97162
	97022			97163
	97024			97165
	97026			97166
	97028			97167
	97032			97530
	97033			97533
	97034			97535
	97035			97750
	97110			97760
	97112			97761
	97113			

SKILLED NURSING SERVICES

Coverage	Code		Coverage	Code
	T1001			T1003
	T1002			

SPECIAL OTORHINOLARYNGOLOGIC SERVICES

Coverage	Code		Coverage	Code
	92507			92556
	92508			92557
	92517			92562
	92518			92563
	92519			92567
	92521			92568
	92522			92570
	92523			92571
	92524			92575
	92526			92577
	92540			92579
	92541		KBH-EPSDT	92582
	92542			92587
	92544			92650
	92545			92651
	92550			92652
	92551			92653
	92552			
	92553			
	92555			

CODES Updated 12/18

SPECIAL OTORHINOLARYNGOLOGIC SERVICES continued

Coverage	Code		Coverage	Code
	92610			92616
	92611			92620
	92612			92625
	92614			

SUPPLIES

Coverage	Code		Coverage	Code
KBH-EPSDT	L8621		PA*	V5221
KBH-EPSDT	L8622		KBH-EPSDT, PA*	V5230
KBH-EPSDT	L8623		PA*	V5240
KBH-EPSDT	L8624		PA*	V5241
	V5014		PA*	V5242
PA*	V5030		PA*	V5243
PA*	V5040		PA*	V5244
PA*	V5050		PA*	V5245
PA*	V5060		PA*	V5246
KBH-EPSDT, PA*	V5070		PA*	V5247
KBH-EPSDT, PA*	V5080		PA*	V5248
PA*	V5090		PA*	V5249
PA*	V5120		PA*	V5250
PA*	V5130		PA*	V5251
PA*	V5140		PA*	V5252
KBH-EPSDT, PA*	V5150		PA*	V5253
PA*	V5160		PA*	V5254
PA*	V5171		PA*	V5255
PA*	V5172		PA*	V5256
PA*	V5181		PA*	V5257
KBH-EPSDT, PA*	V5190		PA*	V5258
PA*	V5200		PA*	V5259
PA*	V5211		PA*	V5260
PA*	V5212		PA*	V5261
PA*	V5213			V5264
PA*	V5214			V5266
PA*	V5215		MN	V5299

TESTS AND MEASUREMENTS

Coverage	Code		Coverage	Code
	97750			

OCCUPATIONAL/PHYSICAL/SPEECH THERAPY/DME SUPPLY CODES Updated 02/23

Effective with dates of service on or after March 1, 2023, the following procedure codes must include the Ordering, Referring, Prescribing (ORP) National Provider Identifier (NPI) on claims billed for occupational therapy (OT), physical therapy (PT), speech therapy (ST), and durable medical equipment (DME) supplies by PT/PS 08/183 – Early Childhood Intervention (ECI). Claims without an ORP NPI in the ORP field will be denied.

92507	92508	92526	92541	92542	92544
92545	97010	97012	97014	97018	97022
97024	97026	97028	97032	97033	97034
97035	97110	97112	97113	97116	97124
97140	97150	97530	97535	97750	97760
97761	V5030	V5040	V5050	V5060	V5070
V5080	V5120	V5130	V5140	V5150	V5171
V5172	V5181	V5190	V5211	V5212	V5213
V5214	V5215	V5221	V5230	V5242	V5243
V5244	V5245	V5246	V5247	V5248	V5249
V5250	V5251	V5252	V5253	V5254	V5255
V5256	V5257	V5258	V5259	V5260	V5261