KANSAS
MEDICAL ASSISTANCE PROGRAM
PROVIDER MANUAL
Audiology
PART II
AUDIOLOGY PROVIDER MANUAL

Introduction

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BENEFITS AND LIMITATIONS

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FORMS

All forms pertaining to this provider manual can be found on the public website at https://www.kmap-state-ks.us/Public/forms.asp and on the secure website at https://www.kmap-state-ks.us/provider/security/logon.asp.

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

The **Billing Instructions** subsection gives information on accessing the forms and directions applicable to audiology services. An example of the billing form applicable to audiology services is followed by directions for completing and submitting it.

The **Benefits and Limitations** subsection defines specific aspects of the scope of audiology services allowed within the KHPA Medical Plans.

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

**HIPAA Compliance**

As a KMAP participant, providers are required to comply with compliance reviews and complaint investigations conducted by the secretary of the Department of Health and Human Services 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. Providers are required to furnish the Department of Health and Human Services all information required by the department during its review and investigation. The provider is required 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.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review, or investigation, including the relevant questioning of the provider’s employees. The provider shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.
7000. AUDIOLOGY BILLING INSTRUCTIONS  Updated 11/09

Introduction to the CMS-1500 Claim Form

Audiology providers must use the CMS-1500 red claim form (unless submitting electronically) when requesting payment for medical services and supplies provided under the KHPA Medical Plans. Any CMS-1500 claim form not submitted on the red claim form will be returned to the provider. The Kansas MMIS uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information is not recognized if not submitted in the correct fields as instructed. Billing for Audiology services now requires the use of left (LT) and right (RT) modifiers on all monaural services. If services are binaural, the use of left and right modifiers is not allowed.


The fiscal agent does not furnish the CMS-1500 claim form to providers. Refer to the Form Reordering section of the General Billing Provider Manual.

SUBMISSION OF CLAIM

Send completed first page of each claim and any necessary attachments to:

KHPA Medical Plans
Office of the Fiscal Agent
P.O. Box 3571
Topeka, KS  66601-3571
Introduction to the Explanation of Necessity for Hearing Aid

Audiology providers must submit the Explanation of Necessity for Hearing Aids form with the General Prior Authorization Request Form to Medicaid before approval for a replacement hearing aid is considered. Providers may photocopy this form from the website manual. An example of this form is in the Forms Section at the end of this manual on the public website at [https://www.kmap-state-ks.us/Public/forms.asp](https://www.kmap-state-ks.us/Public/forms.asp) and on the secure website at [https://www.kmap-state-ks.us/provider/security/logon.asp](https://www.kmap-state-ks.us/provider/security/logon.asp). Instructions for completing the form are given below.

*Note:* Please note the asterisk statement at the bottom of pages 1 and 2 of the Explanation of Necessity for Hearing Aids form, which reads "Failure to complete this form in its entirety will result in the return of the prior authorization."

Completing the Explanation of Necessity for Hearing Aids Form

The patient information at the top of the form (patient’s name, address, age, and ID number) is generally completed by the provider dispensing the replacement hearing aid.

**Section I Medical Evaluation:**
This section must be completed by a physician (M.D. or D.O.).

**Section II Hearing Evaluation:**
This section must be completed by the otologist, certified audiologist, or hearing aid dealer who performed the hearing acuity test.

*Note:* If the beneficiary is non-English speaking, a speech awareness threshold (SAT) is required in place of a speech reception threshold (SRT).

**Section III Certification for Dispensing of Hearing Aid:**
This section must be completed by the provider who dispenses the replacement hearing aid.

**Section IV Final Fitting:**
This section must be completed by the provider who dispenses the replacement hearing aid.
Dispensing Fees:
One dispensing fee is allowed for binaural and bicros hearing aids. Bill one unit.

Hearing Aid Batteries:
If the hearing aid batteries exceed six per month, indicate in field 21 if services are for a binaural hearing aid.

When dispensing multiple months' supply of batteries, note this in field 19. Enter the number of months, the manufacturer's battery stock number, and whether silver or mercury.

One unit = one battery.

Ordering Date:
The date of receipt of the prescription (ordering date) is considered the date of service, and the provider may bill Medicaid before the actual dispensing of the item(s), since the intent to render service has been confirmed by the acceptance of the prescription.
BENEFITS AND LIMITATIONS

8100. COPAYMENT [Updated 11/09]

Audiology services require a copayment of $3 per date of service. (Refer to Section 3000 of the General Third Party Liability Payment Provider Manual for exceptions.)

Bill all services that occur on the same date on the same claim form. Do not reduce charges or balance due by the copayment amount. The fiscal agent makes this reduction automatically.

If multiple claims are submitted for the same date(s) of service, the copayment is deducted for each claim submitted.

*Exception:* Hearing aid batteries are exempt from copayment if no other audiological services are provided on the same date of service.
8300. Benefit Plan  Updated 08/08

KMAP beneficiaries are assigned to one or more Medical Assistance benefit plans. The assigned plan or plans are listed on the beneficiary ID card. These benefit plans entitle the beneficiary to certain services. From the provider’s perspective, these benefit plans are very similar to the type of coverage assignment in the previous MMIS. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the General Benefits Provider Manual for information on the plastic State of Kansas Medical Card and eligibility verification contact the Medical Assistance Customer Service Center at 1-800-933-6593 or (785) 274-5990.
BENEFITS AND LIMITATIONS

8400. MEDICAID Updated 02/09

Accessories
Medically necessary accessories, after supplied as part of the initial cost, are not covered.

Exceptions:
1. Ear molds are considered content of service of the hearing aid for three months after the dispensing date.
2. When two ear molds are ordered by the physician or audiologist for a monaural aid, the first ear mold is considered part of the dispensing fee. However, a reasonable fee will be allowed for the second mold.

Batteries
Only six batteries are covered per month for monaural aids and 12 per month for binaural aids. Batteries for use with cochlear devices are limited to lithium ion (three per 30 days) and zinc air (six per 30 days). Batteries for cochlear devices are covered for KAN Be Healthy (KBH) eligible beneficiaries only. Only one type of battery is allowed every 30 days.

Prior authorization (PA) in excess of these limitations will not be approved.

Binaural
Fitting of binaural hearing aids are covered, with documentation on the hearing evaluation form, for the following:
- Children under 21 years of age, KBH not required
- A legally blind adult with significant bilateral hearing loss
- A previous binaural hearing aid user
- An occupational requirement for binaural listening

Specific medical necessity documentation must be provided supporting the need for a binaural versus a monaural aid. The documentation must include tests conducted in a commercially available sound suite (or equivalent quiet room), including the beneficiary’s speech reception threshold and speech discrimination ability under the following conditions:
- Standard listening conditions with earphones
- Listening with a monaural fitting
- Listening with a binaural fitting

Note: Improvement beyond a chance level of variation must be demonstrated for both speech reception threshold and speech discrimination ability.

Bone Anchored Hearing Aid
Effective with dates of service on and after March 1, 2009, a bone anchored hearing aid (BAHA) is covered by KMAP with the following specifications and limitations. A BAHA is limited to one every four years, with one replacement. PA is required for all BAHA services. All providers must obtain a PA prior to providing service.
Bone Anchored Hearing Aid (continued)

A BAHA is covered with PA for a KBH beneficiary who meets all of the following criteria:

- Each of items one, two, three and four
- Either items five or six
- At least one of items seven, eight or nine

1. The beneficiary must be five years of age or older.
2. Standard hearing aids cannot be used due to a medical condition.
3. The beneficiary has adequate manual dexterity or the assistance necessary to snap the device onto the abutment.
4. The beneficiary has the ability to maintain proper hygiene at the site of the fixture.
5. Tumors of the external canal and/or tympanic cavity are present.
6. Congenital or surgically induced malformations (e.g., atresia) of the external ear canal or middle ear are present.
7. There is unilateral conductive or mixed hearing loss.
8. There is bilateral conductive hearing loss.
9. There is unilateral sensorineural hearing loss (single-sided deafness).

Definitions

- **Unilateral conductive or mixed hearing loss**: Unilateral conductive or mixed hearing loss caused by congenital malformations of the external or middle ear. Conventional hearing aids cannot be worn. Beneficiary must have:
  - Average bone conduction threshold better (less) than 45 dB (at 500, 1000, 2000, 3000 Hz) in the indicated ear
  - Speech discrimination score greater than 60 percent in the indicated ear

- **Bilateral conductive hearing loss**: Conductive and mixed hearing loss involving both ears which is not able to be treated with reconstructive surgery or conventional hearing aids. Beneficiary must meet all of the following:
  - Moderate (40dB) to severe (70dB) conductive hearing loss symmetrically
  - Less than 10dB difference in average bone conduction (at 500, 1000, 2000, 4000 Hz) or less than 15 dB difference in bone conduction at individual frequencies
  - Mixed hearing loss with an average bone conduction better (less) than 45dB in either ear (at 500, 1000, 2000, 4000 Hz)

- **Unilateral sensorineural hearing loss (single-sided deafness)**: Nerve deafness in the indicated ear making conventional hearing aids no longer useful. The implant is designed to stimulate the opposite (good ear) by bone conduction through the bones of the skull. Therefore, the audiometric criteria are for the good ear. Beneficiary must meet all of the following:
  - Severe (70dB) to profound (90dB) hearing loss on one side with poor speech discrimination and the inability to use a conventional hearing aid in that ear
  - Normal hearing in the good ear as defined by an air conduction threshold equal to or better (less) than 20dB (at 500, 1000, 2000, 3000 Hz)
Bone Anchored Hearing Aid (continued)

A child younger than five years of age with unilateral congenital atresia of the ear canal or middle ear in the presence of a maximum conductive hearing loss and adequate cochlear (inner ear) function may be considered on an individual basis. Adequate cochlear function is demonstrated audiologically when stimulation through bone conduction results in significantly improved and functional hearing in the involved ear.

For a child with congenital malformations, sufficient bone volume and bone quality must be present for a successful fixture implantation. Alternative treatments, such as a conventional bone conduction hearing aid, should be considered for a child with a disease state that might jeopardize osseointegration.

Replacements

- One replacement BAHA is covered for a KBH beneficiary who meets the initial placement criteria.
- PA is required for all BAHA replacement services. All providers must obtain a PA prior to providing service.
- A replacement processor cannot be billed at the same time as the original processor or the original surgery.
- Replacements are limited to one every four years if lost, stolen, or broken.
- A replacement is not allowed for the purpose of upgrading. A BAHA can only be replaced if the current processor has an expired warranty, is malfunctioning, and cannot be repaired.

Cochlear Implant

Cochlear implants, devices, accessories, repairs, and batteries are a covered service for KBH-eligible beneficiaries. These services are no longer restricted to one provider. Code 69930 is allowed without PA. Codes 69930 and L8614 must be billed on the same claim form, or the claim will deny.

Before cochlear services can be provided out of state, providers must request and receive approval (PA) from KMAP. Diagnostic analysis of cochlear implants may be a covered service for KBH-eligible beneficiaries.

Use of the left (LT) or right (RT) modifiers is required on all claims for cochlear implantation, original device, headset/headpiece, microphone, transmitting coil, transmitting cable, replacement processors, accessories and repairs, regardless of the provider. Headset/headpiece, microphone, and transmitting coils may be replaced once per year for KBH-eligible beneficiaries.
Cochlear Implant (continued)

Cochlear external speech processor replacements are allowed no more than one time every four years with PA for KBH-eligible beneficiaries. Cochlear external speech processor replacements will only be allowed if current processor is malfunctioning out of warranty and cannot be repaired. Replacements for upgrades will not be allowed. Replacements for lost cochlear external speech processors will be allowed one time during the four-year period for KBH-eligible beneficiaries.

Three lithium ion batteries for codes L8623 and L8624 are allowed for KBH-eligible beneficiaries per 30 days. Codes L8621 and L8622 for cochlear implant devices are allowed for KBH-eligible beneficiaries per 30 days. Only one type of battery is allowed every 30 days.

Dispensing

Only one dispensing fee is allowed for monaural or binaural services. The appropriate dispensing fee must be used. **DO NOT BILL TWO DISPENSING FEES.** If services are monaural, the left or right modifier must be submitted on the claim. If the services are binaural, the left and right modifiers are not allowed. Hearing aid dispensing services include adjusting the aid to meet the beneficiary's medical need. If the aid cannot be adjusted to meet the beneficiary's need within the one-month trial period, the aid is to be replaced or returned to the dispenser.

If the aid is returned, Medicaid will cover one month's rental, not to exceed $65 plus the cost of the ear mold.

Documentation

To verify services provided in the course of a postpayment review, documentation in the beneficiary's medical record must support the service billed.

Eyeglasses

The cost of the hearing aid only is covered in eyeglasses with hearing aids for beneficiaries not participating in the KBH program.

Reimbursement for incorporation of the eyeglasses with the hearing aid is covered with PA for KBH participants.

Hearing Aids

Initial hearing aids do not require PA. Documentation supporting the need for the hearing aid still needs to be available in the beneficiary’s record.

The use of the left or right modifier with monaural services is required. Claims will be denied if the appropriate modifier is not used. The use of the left or right modifier with binaural services is not allowed. Claims will be denied if the modifiers are used.
Hearing Aids (continued)

All hearing aids must be covered by a six-month warranty. Hearing aid replacements may be reimbursed only once in a four-year period. The four-year period starts with the initial hearing aid and does not begin again if the aid is replaced.

Hearing aids that are lost, broken, or destroyed may be replaced (with PA) once during the four-year period when documentation of the circumstances demonstrates the need. The Explanation of Necessity for Hearing Aids form and General Prior Authorization Request Form must be submitted for PA. (Refer to Section 4300 of the General Special Requirements Provider Manual and Section 7010 of this manual for complete instructions.)

Repairs

Repairs must be covered by a six-month warranty.

Repairs of $14.99 or less are not covered.

Repairs of $15 to $75 are covered without PA.

Repairs exceeding $75 require PA. Authorization will be given only when, in the consultant’s opinion, the repairs are not extensive enough to warrant the fitting and dispensing of a new hearing aid.

Replacement Supplies

Replacement cords for hearing instruments and cochlear implants are covered with medical necessity documentation.

Code V5299 is only to be used for a replacement cord for analog or digital hearing aids with proper medical necessity documentation. Use the covered codes for cochlear devices.

Testing, Examination, and Fitting

Only enrolled physicians and licensed or certified audiologists will be reimbursed for hearing tests. Certified program for otolaryngology personnel (CPOP) technicians are not allowed to enroll. All services performed by a CPOP technician must be billed through an otolaryngologist.

Basic hearing services can be performed by CPOP technicians under the following guidelines:

- The CPOP technician must be certified by the American Academy of Otolaryngology which includes sponsorship by an otolaryngologist. Certification documentation must be on file in the ear, nose and throat (ENT) facility.
- Services may only be performed in the office of an enrolled ENT specialist.
- The CPOP technician must be directly supervised by an otolaryngologist.
- All CPOP services must be signed off by an otolaryngologist. The otolaryngologist assumes all responsibility for CPOP technicians and services provided.

Note: For KAN Be Healthy screening guidelines, see Section 2020 of the General Benefits Provider Manual.
Testing, Examination, and Fitting (continued)

A physician must examine the hearing aid beneficiary for pathology or disease no more than six months prior to the fitting of the aid. Only physicians and licensed or certified audiologists will be reimbursed for hearing tests.

An otologist, certified audiologist, or hearing aid dealer must perform hearing tests on the beneficiary prior to the fitting and dispensing date.

Codes 92555 and 92557 may be repeated one time for hearing aid fit evaluation.

Codes 92551 and 92587 are limited to one service per day.
APPENDIX

CODES  Updated 11/09

The following procedure codes represent an all-inclusive list of audiology services billable to the KHAP Medical Plans. Procedures not listed here are considered noncovered.

Please use the following resources to determine current coverage and pricing information. For accuracy, use your provider type and specialty as well as the beneficiary ID number or benefit plan.

- Information from the public website is available at: https://www.kmap-state-ks.us/Provider/PRICING/RefCode.asp.
- Information from the secure website is available under Pricing and Limitations at: https://www.kmap-state-ks.us/provider/security/logon.asp.

A chart has been developed to assist providers in understanding how KHAP will handle specific modifiers. The Coding Modifiers chart is available on both the public and secure websites. It is under Reference Codes on the main provider page and Pricing and Limitations on the secure portion.


COVERAGE INDICATORS

KBH = KAN Be Healthy medical participation is required
MN = Medical necessity documentation is required
PA = Prior authorization is required
PA* = Refer to Repairs, Section 8400
PA** = PA for replacement only
RR = One month trial rental

Refer to Section 8400 for additional benefits and limitations.

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</tbody>
</table>