

# Services That Are Subject To Post Service Review

REV: 04/2011

Codes w/ PS edits	Description
11400	EXCISION, BENIGN LESION INCL MARGINS EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE) TRUNK, ARMS, OR LEGS; EX DIAM 0.5CM ORLESS
11401	EXCISION, BENIGN LESION INCL MARGINS, EXCEPT SKIN TAG (UNLS LISTED ELSEWHR) TRUNK, ARMS, OR LEGS; EX DIAM 0.6 TO 1.0CM
11402	EXCISION, BENIGN LESION INCL MARGINS, EXCEPT SKIN TAG (UNLS LISTED ELSEWHR) TRUNK, ARMS, OR LEGS; EX DIAM 1.1 TO 2.0CM
11403	EXCISION, BENIGN LESION INCL MARGINS, EXCEPT SKIN TAG (UNLS LISTED ELSEWHR) TRUNK, ARMS, OR LEGS; EX DIAM 2.1 TO 3.0CM
11404	EXCISION, BENIGN LESION INCL MARGINS, EXCEPT SKIN TAG (UNLS LISTED ELSEWHR) TRUNK, ARMS, OR LEGS; EX DIAM 3.1 TO 4.0CM
11406	EXCISION, BENIGN LESION INCL MARGINS, EXCEPT SKIN TAG (UNLS LISTED ELSEWHR) TRUNK, ARMS, OR LEGS; EX DIAM OVER 4.0CM
11420	EXCISION, BENIGN LESION INCL MARGINS, EXPT SKIN TAG (UNLS LSTD ELSWR) SCALP, NECK, HNDS, FEET, GENIT; EX DM 0.5CM OR LSS
11421	EXCISION, BENIGN LESION INCL MARGINS, EXPT SKIN TAG (UNLS LSTD ELSWR) SCALP, NECK, HNDS, FEET, GENIT; EX DM 0.6 TO 1.0CM
11422	EXCISION, BENIGN LESION INCL MARGINS, EXPT SKIN TAG (UNLS LSTD ELSWR) SCALP, NECK, HNDS, FEET, GENIT; EX DM 1.1 TO 2.0CM
F11423	EXCISION, BENIGN LESION INCL MARGINS, EXPT SKIN TAG (UNLS LSTD ELSWR) SCALP, NECK, HNDS, FEET, GENIT; EX DM 2.1 TO 3.0CM
11424	EXCISION, BENIGN LESION INCL MARGINS, EXPT SKIN TAG (UNLS LSTD ELSWR) SCALP, NECK, HNDS, FEET, GENIT; EX DM 3.1 TO 4.0CM
11426	EXCISION, BENIGN LESION INCL MARGINS, EXPT SKIN TAG (UNLS LSTD ELSWR) SCALP, NECK, HNDS, FEET, GENIT; EX DIAM OVER 4CM
11440	EXCISION, BENIGN LESION INCL MARGINS, (UNLS LSTD ELSWR) FACEEARS, EYELIDS, NOSE, LIPS, MUCOUS MEMB, EX DIAM 0.5CM ORLESS
11441	EXCISION, BENIGN LESION INCL MARGINS, (UNLS LSTD ELSWR) FACEEARS, EYELIDS, NOSE, LIPS, MUCOUS MEMB, EX DIAM 0.6 TO 1.0CM
11442	EXCISION, BENIGN LESION INCL MARGINS, (UNLS LSTD ELSWR) FACEEARS, EYELIDS, NOSE, LIPS, MUCOUS MEMB, EX DIAM 1.1 TO 2.0CM
11443	EXCISION, BENIGN LESION INCL MARGINS, (UNLS LSTD ELSWR) FACEEARS, EYELIDS, NOSE, LIPS, MUCOUS MEMB, EX DIAM 2.1 TO 3.0CM
11444	EXCISION, BENIGN LESION INCL MARGINS, (UNLS LSTD ELSWR) FACEEARS, EYELIDS, NOSE, LIPS, MUCOUS MEMB, EX DIAM 3.1 TO 4.0CM



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

11446	EXCISION, BENIGN LESION INCL MARGINS, (UNLS LSTD ELSWR) FACEEARS, EYELIDS, NOSE, LIPS, MUCOUS MEMB, EX DIAM OVER 4.0CM
11920	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGM
11921	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGM
11922	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGM
11950	SUBCUTANEOUS INJECTION OF "FILLING" MATERIAL (EG, COLLAGEN); 1 CC OR LESS
11951	SUBCUTANEOUS INJECTION OF "FILLING" MATERIAL (EG, COLLAGEN); 1.1 TO 5.0 CC
11952	SUBCUTANEOUS INJECTION OF "FILLING" MATERIAL (EG, COLLAGEN); 5.1 TO 10.0 CC
11954	SUBCUTANEOUS INJECTION OF "FILLING" MATERIAL (EG, COLLAGEN); OVER 10.0 CC
11960	INSERTION OF TISSUE EXPANDER(S)
11971	REMOVAL OF TISSUE EXPANDER(S) WITHOUT INSERTION OF PROSTHESIS
11980	SUBCUTANEOUS HORMONE PELLET IMPLANTATION
12031	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); 2.5 CM OR LESS
12032	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES ( EXCLUDING HANDS AND FEET); 2.6 CM TO 7.5
12034	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); 7.6 CM TO 12.5
12035	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); 12.6 CM TO 20.
12036	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); 20.1 CM TO 30.
12037	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); OVER 30.0 CM
12041	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; 2.5 CM OR LESS
12042	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; 2.6 CM TO 7.5 CM
12044	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; 7.6 CM TO 12.5 CM
12045	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; 12.6 CM TO 20.0 CM
12046	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; 20.1 CM TO 30.0 CM
12047	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; OVER 30.0 CM
12051	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 2.5 CM OR LESS
12052	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 2.6 CM TO 5.0 CM



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

12053	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 5.1 CM TO 7.5 CM
12054	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 7.6 CM TO 12.5 CM
12055	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 12.6 CM TO 20.0 CM
12056	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 20.1 CM TO 30.0 CM
12057	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; OVER 30.0 CM
13100	REPAIR, COMPLEX, TRUNK; 1.1 CM TO 2.5 CM
13101	REPAIR, COMPLEX, TRUNK; 2.6 CM TO 7.5 CM
13102	REPAIR, COMPLEX, TRUNK; EACH ADDITIONAL 5 CM OR LESS
13120	REPAIR, COMPLEX, SCALP, ARMS, AND/OR LEGS; 1.1 CM TO 2.5 CM
13121	REPAIR, COMPLEX, SCALP, ARMS, AND/OR LEGS; 2.6 CM TO 7.5 CM
13122	REPAIR, COMPLEX, SCALP, ARMS, AND/OR LEGS; EACH ADDITIONAL 5 CM OR LESS
13131	REPAIR, COMPLEX, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; 1.1 CM TO 2.5 CM
13132	REPAIR, COMPLEX, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; 2.6 CM TO 7.5 CM
13133	REPAIR, COMPLEX, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; EACH ADDITIONAL 5 CM OR LES
13150	REPAIR, COMPLEX, EYELIDS, NOSE, EARS AND/OR LIPS; 1.0 CM OR LESS
13151	REPAIR, COMPLEX, EYELIDS, NOSE, EARS AND/OR LIPS; 1.1 CM TO 2.5 CM
13152	REPAIR, COMPLEX, EYELIDS, NOSE, EARS AND/OR LIPS; 2.6 CM TO 7.5 CM
13153	REPAIR, COMPLEX, EYELIDS, NOSE, EARS AND/OR LIPS; EACH ADDITIONAL 5 CM OR LESS
14000	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, TRUNK; DEFECT 10 SQ CM OR LESS
14001	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, TRUNK; DEFECT 10.1 SQ CM TO 30.0 SQ CM
14020	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, SCALP, ARMS AND/OR LEGS; DEFECT 10 SQ CM OR LESS
14021	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, SCALP, ARMS AND/OR LEGS; DEFECT 10.1 SQ CM TO 30.0 SQ CM
14040	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEE
14041	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEE
14060	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, NOSE, EARS AND/OR LIPS; DEFECT 10 SQ CM OR LESS
14061	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, NOSE, EARS AND/OR LIPS; DEFECT 10.1 SQ CM TO 30.0 SQ CM
14301	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, ANY AREA



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

14302	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, ANY AREA, EACH ADDITIONAL 30.0 SQ CM
15150	TISSUE CULTURED EPIDERMAL AUTOGRAFT, TRUNK, ARMS, LEGS; FIRST 25 SQ CM OR LESS
15151	TISSUE CULTURED EPIDERMAL AUTOGRAFT, TRUNK, ARMS, LEGS; ADDITIONAL 1 TO 75 SQ CM
15152	TISSUE CULTURED EPIDERMAL AUTOGRAFT, TRUNK, ARMS, LEGS; EACH ADDITIONAL 100 SQ CM
15155	TISSUE CULTURED EPIDERMAL AUTOGRAFT; FIRST 25 SQ CM OR LESS OR 1% OF BODY AREA OF INFANTS AND CHILDREN; FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORGITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS;
15156	TISSUE CULTURED EPIDERMAL AUTOGRAFT; EACH ADDITIONAL 1 TO 75 SQ CM; SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, FACE, SCALP, EYELIDS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS
15157	TISSUE CULTURED EPIDERMAL AUTOGRAFT; EACH ADDITIONAL 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN; FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS
15170	ACELLULAR DERMAL REPLACEMENT, TRUNK, ARMS, LEGS; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN
15171	ACELLULAR DERMAL REPLACEMENT, TRUNK, ARMS, LEGS; EACH ADDITIONAL 100 SQ CM, OR 1% OF BODY AREA OF INFANTS AND CHILDREN
15175	ACELLULAR DERMAL REPLACEMENT; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN; FACE, SCALP, EYELIDS,
15176	ACELLULAR DERMAL REPLACEMENT; EACH ADDITIONAL 100 SQ CM, OR 1% OF BODY AREA OF INFANTS AND CHILDREN; FACE, SCALP, EYELIDS
15330	ACELLULAR DERMAL ALLOGRAFT, TRUNK, ARMS, LEGS; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN
15331	ACELLULAR DERMAL ALLOGRAFT, TRUNK, ARMS, LEGS; EACH ADDITIONAL 100 SQ CM, OR 1% OF BODY AREA OF INFANTS AND CHILDREN
15335	ACELLULAR DERMAL ALLOGRAFT; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN; FACE, SCALP, EYELIDS, MO
15336	ACELLULAR DERMAL ALLOGRAFT; EACH ADDITIONAL 100 SQ CM, OR 1% OF BODY AREA OF INFANTS AND CHILDREN; FACE, SCALP, EYELIDS
15340	TISSUE CULTURED ALLOGENEIC SKIN SUBSTITUTE; FIRST 25 SQ CM OR LESS
15341	TISSUE CULTURED ALLOGENEIC SKIN SUBSTITUTE; EACH ADDITIONAL 25 SQ CM
15360	TISSUE CULTURED ALLOGENEIC DERMAL SUBSTITUTE; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN; TRUNK, ARMS, LEGS
15361	TISSUE CULTURED ALLOGENEIC DERMAL SUBSTITUTE; EACH ADDITIONAL 100 SQ CM, OR 1% OF BODY AREA OF INFANTS AND CHILDREN; TRUNK, ARMS, LEGS
15365	TISSUE CULTURED ALLOGENEIC DERMAL SUBSTITUTE; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN; FACE,
15366	TISSUE CULTURED ALLOGENEIC DERMAL SUBSTITUTE; EACH ADDITIONAL 100 SQ CM, OR 1% OF BODY AREA OF INFANTS AND CHILDREN; FACE, SCALP, EYELIDS
15400	XENOGRAFT, SKIN, FOR TEMPORARY WOUND CLOSURE; TRUNK, ARMS, LEGS; FIRST 100 SQ CM OR LESS, OR ONE PERCENT OF BODY AREA OF I



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

15401	XENOGRAFT, SKIN, FOR TEMPORARY WOUND CLOSURE; TRUNK, ARMS, LEGS; EACH ADDTL 100 SQ CM OR ONE PERCENT OF BODY AREA OF INFAN
15420	XENOGRAFT SKIN (DERMAL), FOR TEMPORARY WOUND CLOSURE; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN
15421	XENOGRAFT SKIN (DERMAL), FOR TEMPORARY WOUND CLOSURE; EACH ADDITIONAL 100 SQ CM, OR 1% OF BODY AREA OF INFANTS AND CHILDREN
15430	ACELLULAR XENOGRAFT IMPLANT; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN
15431	ACELLULAR XENOGRAFT IMPLANT; EACH ADDITIONAL 100 SQ CM, OR 1% OF BODY AREA OF INFANTS AND CHILDREN
15775	PUNCH GRAFT FOR HAIR TRANSPLANT; 1 TO 15 PUNCH GRAFTS
15776	PUNCH GRAFT FOR HAIR TRANSPLANT; MORE THAN 15 PUNCH GRAFTS
15780	DERMABRASION; TOTAL FACE (EG, FOR ACNE SCARRING, FINE WRINKLING, RHYTIDS, GENERAL KERATOSIS)
15781	DERMABRASION; SEGMENTAL, FACE
15782	DERMABRASION; REGIONAL, OTHER THAN FACE
15783	DERMABRASION; SUPERFICIAL, ANY SITE, (EG, TATTOO REMOVAL)
15786	ABRASION; SINGLE LESION (EG, KERATOSIS, SCAR)
15787	ABRASION; EACH ADDITIONAL FOUR LESIONS OR LESS
15788	CHEMICAL PEEL, FACIAL; EPIDERMAL
15789	CHEMICAL PEEL, FACIAL; DERMAL
15792	CHEMICAL PEEL, NONFACIAL; EPIDERMAL
15793	CHEMICAL PEEL, NONFACIAL; DERMAL
15819	CERVICOPLASTY
15820	BLEPHAROPLASTY, LOWER EYELID;
15821	BLEPHAROPLASTY, LOWER EYELID; WITH EXTENSIVE HERNIATED FAT PAD
15822	BLEPHAROPLASTY, UPPER EYELID;
15823	BLEPHAROPLASTY, UPPER EYELID; WITH EXCESSIVE SKIN WEIGHTING DOWN LID
15824	RHYTIDECTOMY; FOREHEAD
15825	RHYTIDECTOMY; NECK WITH PLATYSMAL TIGHTENING (PLATYSMAL FLAP , "P-FLAP")
15826	RHYTIDECTOMY; GLABELLAR FROWN LINES
15828	RHYTIDECTOMY; CHEEK, CHIN AND NECK
15829	RHYTIDECTOMY; SUBCUTANEOUS MUSCULOAPONEUROTIC SYSTEM (SMAS) FLAP
15830	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ABDOMEN, INFRAUMBILICAL PANNICULECTOMY
15832	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); THIGH
15833	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); LEG
15834	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); HIP
15835	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); BUTTOCK
15836	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); ARM
15837	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); FOREARM



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

	OR HAND
15838	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); SUBMENTAL FAT PAD
15839	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); OTHER AREA
15840	GRAFT FOR FACIAL NERVE PARALYSIS; FREE FASCIA GRAFT (INCLUDING OBTAINING FASCIA)
15841	GRAFT FOR FACIAL NERVE PARALYSIS; FREE MUSCLE GRAFT (INCLUDING OBTAINING GRAFT)
15842	GRAFT FOR FACIAL NERVE PARALYSIS; FREE MUSCLE FLAP BY MICROSURGICAL TECHNIQUE
15845	GRAFT FOR FACIAL NERVE PARALYSIS; REGIONAL MUSCLE TRANSFER
15847	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ABDOMEN (E.G. ABDOMINOPLASTY)
15876	SUCTION ASSISTED LIPECTOMY; HEAD AND NECK
15877	SUCTION ASSISTED LIPECTOMY; TRUNK
15878	SUCTION ASSISTED LIPECTOMY; UPPER EXTREMITY
15879	SUCTION ASSISTED LIPECTOMY; LOWER EXTREMITY
15999	UNLISTED PROCEDURE, EXCISION PRESSURE ULCER
17106	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); LESS THAN 10 SQ CM
17107	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); 10.0 - 50.0 SQ CM
17108	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); OVER 50.0 SQ CM
17999	UNLISTED PROCEDURE, SKIN, MUCOUS MEMBRANE AND SUBCUTANEOUS TISSUE
19105	ABLATION, CRYOSURGICAL, OF FIBROADENOMA, INCLUDING ULTRASOUND GUIDANCE, EACH FIBROADENOMA
19296	PLACEMENT OF RADIOTHERAPY AFTERLOADING BALLOON CATHETER INTO THE BREAST FOR INTERSTITIAL RADIOELEMENT APPLICATION FOLLOWI
19297	PLACEMENT OF RADIOTHERAPY AFTER LOADING BALLOON CATHETER INTO THE BREAST FOR INTERSTITIAL RADIOELEMENT APPLICATION
19298	PLACEMENT OF RADIOTHERAPY AFTERLOADING BRACHYTHERAPY CATHETERS INTO THE BREAST FOR INTERSTITIAL RADIOELEMENT APPLICATION FOLLOWING PARTIAL MASTECTOMY
19300	MASTECTOMY FOR GYNECOMASTIA
19316	MASTOPEXY
19318	REDUCTION MAMMAPLASTY
19324	MAMMAPLASTY, AUGMENTATION; WITHOUT PROSTHETIC IMPLANT
19325	MAMMAPLASTY, AUGMENTATION; WITH PROSTHETIC IMPLANT
19328	REMOVAL OF INTACT MAMMARY IMPLANT
19330	REMOVAL OF MAMMARY IMPLANT MATERIAL
19340	IMMEDIATE INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTOMY OR IN RECONSTRUCTION
19342	DELAYED INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTOMY OR IN RECONSTRUCTION
19350	NIPPLE/AREOLA RECONSTRUCTION



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

19355	CORRECTION OF INVERTED NIPPLES
19357	BREAST RECONSTRUCTION, IMMEDIATE OR DELAYED, WITH TISSUE EXPANDER, INCLUDING SUBSEQUENT EXPANSION
19361	BREAST RECONSTRUCTION WITH LATISSIMUS DORSI FLAP, WITHOUT PROSTHETIC IMPLANT
19364	BREAST RECONSTRUCTION WITH FREE FLAP
19366	BREAST RECONSTRUCTION WITH OTHER TECHNIQUE
19367	BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP (TRAM), SINGLE PEDICLE, INCLUDING CLOSURE
19368	BREAST RECONSTRUCTION WITH REVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP WITH MICROVASCULAR ANASTOMOSIS
19369	BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP, DOUBLE PEDICLE, INCLUDING CLOSURE OF SITE
19380	REVISION OF RECONSTRUCTED BREAST
19396	PREPARATION OF MOULAGE FOR CUSTOM BREAST IMPLANT
19499	UNLISTED PROCEDURE, BREAST
20200	BIOPSY, MUSCLE; SUPERFICIAL
20205	BIOPSY, MUSCLE; DEEP
20206	BIOPSY, MUSCLE, PERCUTANEOUS NEEDLE
20555	PLACEMENT OF NEEDLES OF CATHETERS INTO MUSCLE AND/OR SOFT TISSUE FOR SUBSEQUENT INTERSTITIAL RADIOELEMENT APPLICATION
20974	ELECTRICAL STIMULATION TO AID BONE HEALING; NONINVASIVE (NONOPERATIVE)
20975	ELECTRICAL STIMULATION TO AID BONE HEALING; INVASIVE (OPERATIVE)
20979	LOW INTENSITY ULTRASOUND STIMULATION TO AID BONE HEALING, NONINVASIVE
20982	ABLATION, BONE TUMOR(S) RADIOFREQUENCY PERCUTANEOUS B170 INCLUDING COMPUTED TOMOGRAPHIC GUIDANCE
20985	COMPUTER-ASSISTED SURG NAVIGATIONAL PROCEDURES FOR MUSCULOSKELETAL PROCEDURES, IMAGE-LESS
20999	UNLISTED PROCEDURE, MUSCULOSKELETAL SYSTEM, GENERAL
21083	IMPRESSION AND CUSTOM PREPARATION; PALATAL LIFT PROSTHESIS
21087	IMPRESSION AND CUSTOM PREPARATION; NASAL PROSTHESIS
21089	UNLISTED MAXILLOFACIAL PROSTHETIC PROCEDURE
21120	GENIOPLASTY; AUGMENTATION
21121	GENIOPLASTY; SLIDING OSTEOTOMY, SINGLE PIECE
21122	GENIOPLASTY; SLIDING OSTEOTOMIES, TWO OR MORE OSTEOTOMIES
21123	GENIOPLASTY; SLIDING, AUGMENTATION WITH INTERPOSITIONAL BONE GRAFTS
21125	AUGMENTATION, MANDIBULAR BODY OR ANGLE; PROSTHETIC MATERIAL
21127	AUGMENTATION, MANDIBULAR BODY OR ANGLE; WITH BONE GRAFT, ONLAY OR INTERPOSITIONAL (INCLUDES OBTAINING AUTOGR
21137	REDUCTION FOREHEAD; CONTOURING ONLY
21138	REDUCTION FOREHEAD; CONTOURING AND APPLICATION OF PROSTHETIC MATERIAL OR BONE GRAFT
21139	REDUCTION FOREHEAD; CONTOURING AND SETBACK OF ANTERIOR FRONTAL SINUS WALL



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

21141	RECONSTRUCTION MIDFACE, LEFORT I; SINGLE PIECE, SEGMENT MOVEMENT IN ANY DIRECTION, WITHOUT BONE GRAFT
21142	RECONSTRUCTION MIDFACE LEFORT I; TWO PIECES SEGMENT MOVEMENT IN ANY DIRECTION, WITHOUT BONE GRAFT
21143	RECONSTRUCTION MIDFACE, LEFORTI; THREE OR MORE PIECES SEGMENT MOVEMENT IN ANY DIRECTION, WITHOUT BONE GRAFT
21145	RECONSTRUCTION MIDFACE, LEFORT I; SINGLE PIECE, ANY DIRECTION, REQUIRING BONE GRAFTS
21146	RECONSTRUCTION MIDFACE, LEFORT I; TWO PIECES, ANY DIRECTION, REQUIRING BONE GRAFTS
21147	RECONSTRUCTION MIDFACE, LEFORT I; THREE OR MORE PIECES, ANY DIRECTION, REQUIRING BONE GRAFTS
21150	RECONSTRUCTION MIDFACE, LEFORT II; ANTERIOR INTRUSION (EG, TREACHER-COLLINS SYNDROME)
21151	RECONSTRUCTION MIDFACE, LEFORT II; ANY DIR
21154	RECONSTRUCTION MIDFACE, LEFORT III
21155	RECONSTRUCTION MIDFACE, LEFORT III (EXTRACRANIAL)
21159	RECONSTRUCTION MIDFACE, LEFORT III (EXTRA AND INTRACRANIAL)
21160	RECONSTRUCTION MIDFACE, LEFORT III (EXTRA AND INTRACRANIAL)
21172	RECONSTRUCTION SUPERIOR-LATERAL ORBITAL RIM AND LOWER FOREHEAD,
21175	RECONSTRUCTION, BIFRONTAL, SUPERIOR-LATERAL ORBITAL RIMS AND LOWER FOREHEAD
21179	RECONSTRUCTION, ENTIRE OR MAJORITY OF FOREHEAD AND/OR SUPRAORBITAL RIMS; WITH GRAFTS
21180	RECONSTRUCTION, ENTIRE OR MAJORITY OF FOREHEAD AND/OR SUPRAORBITAL RIMS; WITH AUTOGRAFT
21188	RECONSTRUCTION MIDFACE, OSTEOTOMIES (OTHER THAN LEFORT TYPE)
21193	RECONSTRUCTION, MANDIBULAR RAMI W/O GRAFT
21194	RECONSTRUCTION, MANDIBULAR RAMI W/GRAFT
21195	RECONSTRUCTION W/O INTERNAL RIGID FIXATION
21196	RECONSTRUCTION OF MANDIBULAR RAMUS, SAGITTAL SPLIT;
21198	OSTEOTOMY, MANDIBLE
21199	OSTEOTOMY, GENIOGLOSSUS ADVANCEMENT
21206	OSTEOTOMY, MAXILLA, SEGMENTAL
21208	OSTEOPLASTY, FACIAL BONES; AUGMENTATION (A
21209	OSTEOPLASTY, FACIAL BONES; REDUCTION
21210	GRAFT, BONE; NASAL, MAXILLARY OR MALAR AREAS
21215	GRAFT, BONE; MANDIBLE (INCLUDES OBTAINING GRAFT)
21230	GRAFT; RIB CARTILAGE, AUTOGENOUS, TO FACE, CHIN, NOSE OR EAR
21235	GRAFT; EAR CARTILAGE, AUTOGRAFT, TO NOSE OR EAR
21244	RECONSTRUCTION OF MANDIBLE, EXTRAORAL, WITH TRANSOSTEAL BONE PLATE (EG, MANDIBULAR STAPLE BONE PLATE)
21245	RECONSTRUCTION OF MANDIBLE OR MAXILLA, SUBPERIOSTEAL IMPLANT; PARTIAL
21246	RECONSTRUCTION OF MANDIBLE OR MAXILLA, SUBPERIOSTEAL IMPLANT; COMPLETE



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

21247	RECONSTRUCTION OF MANDIBULAR CONDYLE WITH BONE AND CARTILAGE
21248	RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT (EG, BLADE, CYLINDER); PARTIAL
21249	RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT (EG, BLADE, CYLINDER); COMPLETE
21255	RECONSTRUCTION OF ZYGOMATIC ARCH AND GLENOID FOSSA WITH BONE
21256	RECONSTRUCTION OF ORBIT WITH OSTEOTOMIES AND BONE GRAFTS
21270	MALAR AUGMENTATION, PROSTHETIC MATERIAL
21299	UNLISTED CRANIOFACIAL AND MAXILLOFACIAL PR
21335	OPEN TREATMENT OF NASAL FRACTURE; WITH CONCOMITANT OPEN TREATMENT OF FRACTURED SEPTUM
21499	UNLISTED MUSCULOSKELETAL PROCEDURE, HEAD
21685	HYOID MYOTOMY AND SUSPENSION
21740	RECONSTRUCTIVE REPAIR OF PECTUS EXCAVATUM
21742	RECONSTRUCTIVE REPAIR OF PECTUS EXCAVATUM
21743	RECONSTRUCTIVE REPAIR OF PECTUS EXCAVATUM
21899	UNLISTED PROCEDURE, NECK OR THORAX
22505	MANIPULATION OF SPINE REQUIRING ANESTHESIA, ANY REGION
22520	PERCUTANEOUS VERTEBROPLASTY, ONE VERTEBRAL
22521	PERCUTANEOUS VERTEBROPLASTY, ONE VERTEBRAL
22522	PERCUTANEOUS VERTEBROPLASTY, ONE VERTEBRAL
22523	PERCUTANEOUS VERTEBRAL AUGMENTATION
22524	PERCUTANEOUS VERTEBRAL AUGMENTATION, UNILATERAL
22525	PERCUTANEOUS VERTEBRAL AUGMENTATION, UNILATERAL
22526	PERCUTANEOUS INTRADISCAL ELECTROTHERMAL ANNULOPLASTY
22527	PERCUTANEOUS INTRADISCAL ELECTROTHERMAL ANNULOPLASTY, ONE OR MORE
22533	ARTHRODESIS, LATERAL EXTRACAVITARY TECHNIQUE, INCLUDING MINIMAL DISKECTOMY TO PREPARE INTERSPACE; LUMBAR (Lumbar Spine Fusion)
22558	ARTHRODESIS, ANTERIOR INTERBODY TECHNIQUE; LUMBAR, WITH BONE GRAFT (Lumbar Spine Fusion )
22612	ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, WITH LOCAL BONE OR BONE ALLOGRAFT AND/OR INTERNAL FIXATION;LUMBAR (Lumbar Spine Fusion)
22630	ARTHRODESIS, POSTERIOR INTERBODY TECHNIQUE, WITH LOCAL BONE OR BONE ALLOGRAFT AND/OR INTERNAL WIRE FIXATION, LUMBAR (Lumbar Spine Fusion)
22856	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY WITH END PLATE PREPARATION (includes osteophyctomy for nerve root or spinal cord decompression and microdissection), SINGLE INTERSPACE; CERVICAL
22857	TOTAL DISC ARTHROPLASTY, ANTERIOR APPROACH
22861	REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, SINGLE INTERSPACE; CERVICAL
22862	REVISION INCL REPLACEMENT OF TOTAL DISC ARTHROPLASTY, ANTERIOR APPROACH
22864	REMOVAL OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, SINGLE



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

	INTERSPACE; CERVICAL
22865	REMOVAL OF TOTAL DISC ARTHROPLASTY, ANTERIOR APPROACH
22899	UNLISTED PROCEDURE, SPINE
22999	UNLISTED PROCEDURE, ABDOMEN, MUSCULOSKELETAL SYSTEM
23700	MANIPULATION UNDER ANESTHESIA, SHOULDER JOINT, INCLUDING APPLICATION OF FIXATION APPARATUS (DISLOCATION EXCLUDED)
23929	UNLISTED PROCEDURE, SHOULDER
24300	MANIPULATION, ELBOW, UNDER ANESTHESIA
24999	UNLISTED PROCEDURE, HUMERUS OR ELBOW
25259	MANIPULATION, WRIST, UNDER ANESTHESIA
25999	UNLISTED PROCEDURE, FOREARM OR WRIST
26340	MANIPULATION, FINGER JOINT, UNDER ANESTHESIA, EACH JOINT
26989	UNLISTED PROCEDURE, HANDS OR FINGERS
27275	MANIPULATION, HIP JOINT, REQUIRING GENERAL ANESTHESIA
27299	UNLISTED PROCEDURE, PELVIS OR HIP JOINT
27412	AUTOLOGOUS CHONDROCYTE IMPLANTATION, KNEE
27415	OSTEOCHONDRAL ALLOGRAFT, KNEE, OPEN
27416	OSTEOCHONDRAL AUTOGRAFT(S), KNEE, OPEN (EG, MOSAICPLASTY)(INCLUDES HARVESTING OF AUTOGRAFT(S))
27599	UNLISTED PROCEDURE, FEMUR OR KNEE
27702	ARTHROPLASTY, ANKLE; WITH IMPLANT ("TOTAL ANKLE)
27703	ARTHROPLASTY, ANKLE; SECONDARY RECONSTRUCTION, TOTAL ANKLE
27860	MANIPULATION OF ANKLE UNDER GENERAL ANESTHESIA (INCLUDES APPLICATION OF TRACTION OR OTHER FIXATION APPARATUS)
27899	UNLISTED PROCEDURE, LEG OR ANKLE
28446	OPEN OSTEOCHONDRAL AUTOGRAFT, TALUS (INCLUDES OBTAINING DRAFT(S))
28890	EXTRACORPOREAL SHOCK WAVE, HIGH ENERGY,
28899	UNLISTED PROCEDURE, FOOT OR TOES
29799	UNLISTED PROCEDURE, CASTING OR STRAPPING
29866	ARTHROSCOPY, KNEE, SURGICAL; OSTEOCHONDRAL
29867	ARTHROSCOPY, KNEE, SURGICAL; OSTEOCHONDRAL
29868	ARTHROSCOPY, KNEE, SURGICAL; MENISCAL TRANSPLANTATION
29892	ARTHROSCOPICALLY AIDED REPAIR OF LARGE OSTEOCHONDRITIS
29900	ARTHROSCOPY, METACARPOPHALANGEAL, JOINT, DIAGNOSTIC, INCLUDES SYNOVIAL BIOPSY
29901	ARTHROSCOPY, METACARPOPHALANGEAL JOINT, SURGICAL; WITH DEBRIDEMENT
29902	ARTHROSCOPY, METACARPOPHALANGEAL JOINT, SURGICAL; WITH REDUCTION OF DISPLACED ULNAR COLLATERAL LIGAMENT
29914	ARTHROSCOPY, HIP, SURGICAL; WITH FEMOROPLASTY (IE, TREATMENT OF CAM LESION)
29915	ARTHROSCOPY, HIP, SURGICAL ; WITH ACETABULOPLASTY (IE, TREATMENT OF PINCER LESION)
29916	ARTHROSCOPY, HIP, SURGICAL ; WITH LABRAL REPAIR
29999	UNLISTED PROCEDURE, ARTHROSCOPY
30110	EXCISION, NASAL POLYP(S), SIMPLE



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

30115	EXCISION, NASAL POLYP(S), EXTENSIVE
30120	EXCISION OR SURGICAL PLANING OF SKIN OF NOSE OR RHINOPHYMA
30130	EXCISION INFERIOR TURBINATE, PARTIAL OR COMPLETE, ANY METHOD
30140	SUBMUCOUS RESECTION INFERIOR TURBINATE, PARTIAL OR COMPLETE
30220	INSERTION, NASAL SEPTAL PROSTHESIS (BUTTON)
30400	RHINOPLASTY, PRIMARY; LATERAL AND ALAR CAR
30410	RHINOPLASTY, PRIMARY; COMPLETE, EXTERNAL P
30420	RHINOPLASTY, PRIMARY; INCLUDING MAJOR SEPT
30430	RHINOPLASTY, SECONDARY; MINOR REVISION (SM
30435	RHINOPLASTY, SECONDARY; INTERMEDIATE REVIS
30450	RHINOPLASTY, SECONDARY; MAJOR REVISION (NA
30465	REPAIR OF NASAL VESTIBULAR STENOSIS
30520	SEPTOPLASTY OR SUBMUCOUS RESECTION, WITH OR WITHOUT CARTILAGE SCORING, CONTOURING OR REPLACEMENT WITH GRAFT
30801	CAUTERY AND/OR ABLATION, MUCOSA OF INFERIOR TURBINATES, UNILATERAL OR BILATERAL, ANY METHOD; SUPERFICIAL
30802	CAUTERY AND/OR ABLATION, MUCOSA OF INFERIOR TURBINATES, UNILATERAL OR BILATERAL, ANY METHOD; INTRAMURAL
30999	UNLISTED PROCEDURE, NOSE
31200	ETHMOIDECTOMY; INTRANASAL, ANTERIOR
31201	ETHMOIDECTOMY; INTRANASAL, TOTAL
31205	ETHMOIDECTOMY; EXTRANASAL, TOTAL
31237	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH BIOPSY, POLYPECTOMY OR DEBRIDEMENT (SEPARATE PROCEDURE)
31254	NASAL ENDOSCOPY, SURGICAL; WITH ETHMOIDECTOMY, PARTIAL
31255	NASAL ENDOSCOPY, SURGICAL; WITH ETHMOIDECTOMY, ANTERIOR AND POSTERIOR
31295	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH DILATION OF MAXILLARY SINUS OSTIUM (EG, BALLOON DILATION), TRANSNASAL OR VIA CANINE FOSSA
31296	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH DILATION OF FRONTAL SINUS OSTIUM (EG, BALLOON DILATION)
31297	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH DILATION OF SPHENOID SINUS OSTIUM (EG, BALLOON DILATION)
31299	UNLISTED PROCEDURE, ACCESSORY SINUSES
31599	UNLISTED PROCEDURE, LARYNX
31627	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC
31643	BRONCHOSCOPY; WITH PLACEMENT OF CATHETER(S) FOR INTRACAVITARY RADIOELEMENT APPLICATION
31899	UNLISTED PROCEDURE, TRACHEA, BRONCHI
32491	LUNG VOLUME REDUCTION
32664	THORACOSCOPY, SURGICAL; WITH THORACIC SYMPATHECTOMY
32998	ABLATION THERAPY REDUCTION OR ERADICATION ONE/MORE PULMONARY
32999	UNLISTED PROCEDURE, LUNGS AND PLEURA
33140	TRANSMYOCARDIAL LASER REVASCULARIZATION



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

33141	TRANSMYOCARDIAL LASER REVASCULARIZATION, BY THORACOTOMY
33202	INSERTION OF EPICARDIAL ELECTRODE(S); OPEN INCISION (EG, THORACOTOMY, MEDIAN STERNOTOMY, SUBXIPHOID APPROACH)
33203	INSERTION OF EPICARDIAL ELECTRODE(S); ENDOSCOPIC APPROACH (EG, THORACOSCOPY, PERICARDIOSCOPY)
33207	PACEMAKER, VENTRICULAR
33208	PACEMAKER, VENTRICULAR & ATRIAL
33211	INSERTION/REPLACEMENT TEMP. ELECTRODES
33213	INSERTION/REPLACEMENT TEMP. ELEC. DUAL
33214	UPGRADE OF IMPLANTED PACEMAKER SYSTEM
33216	INSERTION OF TRANSVENOUS ELECTRODE; SINGLE CHAMBER (1 ELECTRODE) PERMANENT PACEMAKER OR SINGLE CHAMBER PACING CARDIOVERT
33217	UPGRADE DUAL CHAMBER
33224	PACING ELECTRODE
33225	INSERTION OF PACING ELECTRODE, CARDIAC VENOUS SYSTEM, LEFT VENTRICULAR PACING, AT TIME OF INSERT OF PACING CARDIOVERTER
33226	REPOSITION OF ELECTRODE
33240	INSERTION SINGLE/DUAL CHAMBER CVD
33249	INSERTION/REPOSITION ELECTRODE LEAD
33548	VENTRICULAR RESTORATION PROCEDURE
33880	ENDOVASCULAR REPAIR OF DESCENDING THORACIC AORTA; INVOLVING
33881	ENDOVASCULAR REPAIR OF DESCENDING THORACIC AORTA; NOT INVOLVING COVERAGE OF LEFT SUBCLAVIAN ARTERY ORIGIN, INITIAL ENDO
33883	PLACEMENT OF PROXIMAL EXTENSION PROSTHESIS FOR ENDOVASCULAR
33884	PLACEMENT OF PROXIMAL EXTENSION PROSTHESIS FOR ENDOVASCULAR REPAIR OF DESCENDING THORACIC AORTA; EACH ADDTL PROXIMAL EXT
33886	PLACEMENT OF DISTAL EXTENSION PROSTHESIS DELAYED AFTER ENDOVASCULAR REPAIR OF DESCENDING THORACIC AORTA
33889	OPEN SUBCLAVIAN TO CAROTID ARTERY TRANSPOSITION PERFORMED IN CONJUNCTION WITH ENDOVASCULAR REPAIR OF DESCENDING THORACIC
33891	BYPASS GRAFT, WITH OTHER THAN VEIN, TRANSCERVICAL RETROPHARYNGEAL CAROTID-CAROTID, PERFORMED IN CONJUNCTION WITH ENDOVA
33999	UNLISTED PROCEDURE, CARDIAC SURGERY
34800	ENDOVASCULAR REPAIR OF INFRARENAL ABDOMINAL AORTIC ANEURYSM OR DISSECTION; USING AORTO-AORTIC TUBE PROSTHESIS
34802	ENDOVASCULAR REPAIR OF INFRARENAL ABDOMINAL AORTIC ANEURYSM OR DISSECTION; USING MODULAR BIFURCATED PROSTHESIS
34803	ENDOVASCULAR REPAIR OF INFRARENAL ABDOMINAL AORTIC ANEURYSM OR DISSECTION; USING MODULAR BIFURCATED PROSTHESIS
34804	ENDOVASCULAR REPAIR OF INFRARENAL ABDOMINAL AORTIC ANEURYSM OR DISSECTION; USING UNIBODY BIFURCATED PROSTHESIS
34805	ENDOVASCULAR REPAIR OF INFRARENAL ABDOMINAL AORTIC ANEURYSM DISSECTION; USING AORTO-UNIILIAC OR AORTO-UNIFEMORAL PROSTHE



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

34806	TRNSCATHETER PLCMNT OF WIRELESS PHYSIOLOGIC SENSR IN ANEURYSMAL SAC DURING ENDOVASCULAR REPR, INCLDNG RADIOLOGICAL SUPR
34808	ENDOASCULAR PLACEMENT OF ILIAC ARTERY OCCULSION DEVICE
34812	OPEN FEMORAL ARTERY EXPOSURE FOR DELIVERY OF ENDOVASCULAR PROSTHESIS, BY GROIN INCISION, UNILATERAL
34813	PLACEMENT OF FEMORAL-FEMORAL PROSTHETIC GRAFT DURING ENDOVASCULAR AORTIC REPAIR
34820	OPEN ILIAC ARTERY EXPOSURE FOR DELIVERY OF ENDOVASCULAR PROSTHESIS OR ILIAC OCCLUSION DURING ENDOVASUCLAR THERAPY
34825	PLACEMENT OF PROXIMAL OR DISTAL EXTENSION PROSTHESIS;INITIALVESSEL;FOR ENDOVASCULAR REPAIR OF INFRARENAL ABDOMINAL AORTIC
34826	PLACEMENT OF PROXIMAL OR DISTAL EXTENSION PROSTHESIS, FOR ENDOVASCULAR REPAIR OF ABDOMINAL ANEURYSM;EA ADD'L VESSEL
35475	TRANSLUMINAL ANGIOPLASTY, PERCUTANEOUS; BRACHIOCEPHALIC
36260	IMPLANTABLE INTRA-ARTERIAL INFUSION PUMP
36299	UNLISTED PROCEDURE, VASCULAR INJECTION
36468	INJECTION SCLEROSING SOLUTION, LIMB OR TRUNK- SPIDER VEINS SINGLE OR MULTIPLE INJECTIONS
36469	INJECTION SCLEROSING SOLUTION, FACE - SPIDER VEINS SINGLE OR MULTIPLE INJECTIONS
36470	INJECTION OF SCLEROSING SOLUTION, SINGLE VEIN
36471	INJECTION OF SCLEROSING SOLUTION, MULTIPLE VEINS
36475	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY
36476	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY
36478	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY
36479	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY
36515	THERAPEUTIC APHERESIS/PLASMA REINFUSION
36563	INSERTION CENTRAL VENOUS ACCESS W/PUMP
37184	PRIMARY PERCUTANEOUS TRANSLUMINAL MECHANICAL THROMBECTOMY; INITIAL VESSEL; NONCORONARY, ARTERIAL OR ARTERIAL BYPASS GRAFT
37185	PRIMARY PERCUTANEOUS TRANSLUMINAL MECHANICAL THROMBECTOMY; SECOND AND ALL SUBSEQUENT VESSELS WITHIN THE SAME VASCULAR
37204	TRANSCATHETER OCCLUSION OR EMBOLIZATION
37215	INTRAVASCULAR STENT W/EMBOLIC PROTECTION
37216	INTRAVASCULAR STENT W/O EMB. PROTECTION
37501	UNLISTED VASCULAR ENDOSCOPY PROCEDURE
37799	UNLISTED PROCEDURE, VASCULAR SURGERY
38129	UNLISTED LAPAROSCOPY PROCEDURE, SPLEEN
38206	BLOOD-DERIVED HEMATOPOIETIC PROGENITOR CELL HARVESTING FOR TRANSPLANTATION, PER COLLECTION; AUTOLOGOUS
38230	BONE MARROW HARVESTING FOR TRANSPLANTATION
38241	BONE MARROW TRANSPLANTATION; AUTOLOGOUS
38589	UNLISTED LAPAROSCOPY PROCEDURE, LYMPHATIC SYSTEM
38999	UNLISTED PROCEDURE, HEMIC OR LYMPHATIC SYSTEM



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

39499	UNLISTED PROCEDURE, MEDIASTINUM
39599	UNLISTED PROCEDURE, DIAPHRAGM
40799	UNLISTED PROCEDURE, LIPS
40899	UNLISTED PROCEDURE, VESTIBULE OF MOUTH
41019	PLACEMENT OF NEEDLES, CATHETERS, OR OTHER DEVICE(S) INTO HEAD AND/OR NECK REGION
41120	GLOSSECTOMY; LESS THAN ONE-HALF TONGUE
41512	TONGUE BASE SUSPENSION, PERMANENT SUTURE TECHNIQUE
41530	SUBMUCOSAL ABLATION OF THE TONGUE BASE, RADIOFREQUENCY, ONE OR MORE SITES, PER SESSION
41599	UNLISTED PROCEDURE, TONGUE, FLOOR OF MOUTH
41870	PERIODONTAL MUCOSAL GRAFTING
41872	GINGIVOPLASTY
41874	ALVEOPLASTY
41899	UNLISTED PROCEDURE, DENTOALVEOLAR STRUCTURES
42145	PALATOPHARYNGOPLASTY
42299	UNLISTED PROCEDURE, PALATE, UVULA
42699	UNLISTED PROCEDURE, SALIVARY GLANDS OR DUCTS
42999	UNLISTED PROCEDURE, PHARYNX, ADENOIDS, OR TONSILS
43201	ESOPHAGOSCOPY, RIGID OR FLEXIBLE; WITH DIRECTEDSUBMUCOSAL INJECTION(S), ANY SUBSTANCE
43228	ESOPHAGOSCOPY, RIGID OR FLEXIBLE FIBEROPTIC (SPECIFY); FOR ABLATION OF TUMOR OR MUCOSAL LESION (EG, ELECTROCOAGULATION,)
43236	UPPER GASTROINTESTINAL ENDOSCOPY INCL ESOPHAGUS,STOMACH DUODENUM AND/OR JEJUNUM AS APPR:WITH DIRECTEDSUBMUCOSINJEC,ANY
43257	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS
43258	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, STOMACH, AND EITHER THE DUODENUM AND/OR JEJUNUM AS APPROPRIATE;
43289	UNLISTED LAPAROSCOPY PROCEDURE, ESOPHAGUS
43499	UNLISTED PROCEDURE, ESOPHAGUS
43632	GASTRECTOMY, PARTIAL, DISTAL; WITH GASTROJEJUNOSTOMY
43644	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; WITH GASTRIC BYPASS AND ROUX-EN-Y GASTROENTEROSTOMY
43645	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; WITH GASTRIC BYPASS AND SMALL INTESTINE RECONSTRUCTION
43647	LAPAROSCOPY, SURGICAL; IMPLANTATION OR REPLACEMENT OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM
43648	LAPAROSCOPY, SURGICAL; REVISION OR REMOVAL OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM
43659	UNLISTED LAPAROSCOPY PROCEDURE, STOMACH
43770	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; PLACEMENT OF ADJUSTABLE GASTRIC BAND



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

43771	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REVISION OF ADJUSTABLE GASTRIC BAND COMPONENT ONLY
43772	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL OF ADJUSTABLE GASTRIC BAND COMPONENT ONLY
43773	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL AND REPLACEMENT OF ADJUSTABLE GASTRIC BAND COMPONENT ONLY
43774	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL OF ADJUSTABLE GASTRIC BAND AND SUBCUTANEOUS PORT COMPONENT
43775	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; LONGITUDINAL GASTRECTOMY (IE, SLEEVE GASTRECTOMY)
43842	GASTROPLASTY, VERTICAL BANDED, FOR MORBID OBESITY
43843	GASTROPLASTY, OTHER THAN VERTICAL-BANDED,
43845	GASTRIC RESTRICTIVE PROCEDURE WITH PARTIAL
43846	GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRI
43847	GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRI
43848	REVISION, OPEN, OF GASTRIC RESTRICTIVE PROCEDURE
43881	IMPLANTATION OR REPLACEMENT OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM, OPEN
43882	REVISION OR REMOVAL OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM, OPEN
43886	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REVISION OF SUBCUTANEOUS PORT COMPONENT ONLY
43887	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REMOVAL OF SUBCUTANEOUS PORT COMPONENT ONLY
43888	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REMOVAL AND REPLACEMENT OF SUBCUTANEOUS PORT COMPONENT ONLY
43999	UNLISTED PROCEDURE, STOMACH
44132	DONOR ENTERECTOMY (INCLUDING COLD PRESERVA
44133	DONOR ENTERECTOMY, OPEN, W/PREPARATION AND
44135	INTESTINAL ALLOTRANSPLANTATION; FROM CADAV
44136	INTESTINAL ALLOTRANSPLANTATION; FROM A LIV
44238	UNLISTED LAPAROSCOPY PROCEDURE, INTESTINE
44799	UNLISTED PROCEDURE, INTESTINE
44899	UNLISTED PROCEDURE, MECKEL'S DIVERTICULUM
44979	UNLISTED LAPAROSCOPY PROCEDURE, APPENDIX
45499	UNLISTED LAPAROSCOPY PROCEDURE, RECTUM
45999	UNLISTED PROCEDURE, RECTUM
46505	CHEMODENERVATION OF INTERNAL ANAL SPHINCT
46707	REPAIR OF ANORECTAL FISTULA WITH PLUG
46762	SPHINCTEROPLASTY, ANAL, FOR INCONTINENCE, ADULT; IMPLANTATION ARTIFICIAL SPHINCTER
46999	UNLISTED PROCEDURE, ANUS
47120	HEPATECTOMY, RESECTION OF LIVER; PARTIAL LOBECTOMY
47122	HEPATECTOMY, RESECTION OF LIVER; TRISEGMENTECTOMY



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

47125	HEPATECTOMY, RESECTION OF LIVER; TOTAL LEFT LOBECTOMY
47130	HEPATECTOMY, RESECTION OF LIVER; TOTAL RIGHT LOBECTOMY
47370	LAP,SURGICAL,ABLATION OF LIVER TUMOR(S)
47371	LAP;ABLATION OF LIVER TUMOR(S)/CRYOSURGICAL
47379	UNLISTED LAPAROSCOPIC PROCEDURE, LIVER
47380	OPEN ABLATION LIVER TUMOR
47381	OPEN ABLATION LIVER TUMOR/CRYOSURGICAL
47382	ABLATION LIVER TUMOR PERCUT.RADIOFREQ.
47399	UNLISTED PROCEDURE, LIVER
47579	UNLISTED LAPAROSCOPY PROCEDURE, BILIARY TRACT
47999	UNLISTED PROCEDURE, BILIARY TRACT
48550	DONOR PANCREATECTOMY (INCLUDING COLD PRESE
48999	UNLISTED PROCEDURE, PANCREAS
49329	UNLISTED LAPAROSCOPY PROCEDURE, ABDOMEN, PERITONEUM
49659	UNLISTED LAPAROSCOPY PROCEDURE, HEMIOPLASTY
49999	UNLISTED PROCEDURE, ABDOMEN, PERITONEUM AND OMENTUM
50250	ABLATION, OPEN,RENAL MASS LESION
50542	LAPARSOCOPY, SURGICAL; ABLATION OF RENAL MASS LESION(S)
50549	UNLISTED LAPAROSCOPY PROCEDURE, RENAL
50592	ABLATION, RENAL TUMOR,PERCUTANEOUS
50593	ABLATION,RENAL TUMOR(S), UNILATERAL,PERCUTANEOUS, CRYOTHERAPY
50949	UNLISTED LAPAROSCOPIC PROCEDURE, URETER
51715	ENDOSCOPIC INJECTION IMPLANT TO URETHRA
51999	UNLISTED LAPAROSCOPY PROCEDURE, BLADDER
52647	LASER COAGULATION OF PROSTATE
52648	LASER VAPORIZATION OF PROSTATE
52649	LASER ENUCLEATION OF THE PROSTATE WITH MORCELLATION, INCLUDING CONTROL OF POSTOP BLEEDNG,COMPLETE VASECTOMY,MEATOTOMY
53850	TRANSURETHRAL DESTRUCTION/PROSTATE TISSUE
53852	BY RADIOFREQUENCY THERMOTHERAPY
53855	INSERTION OF A TEMPORARY PROSTATIC URETHRAL STENT
53860	TRANSURETHRAL RADIOFREQUENCY MICRO-REMODELING OF THE FEMALE BLADDER NECK AND PROXIMAL URETHRA FOR STRESS URINARY INCONTINENCE
53899	UNLISTED PROCEDURE, URINARY SYSTEM
54360	PLASTIC OPERATION ON PENIS TO CORRECT ANGULATION
54440	PLASTIC OPERATION OF PENIS FOR INJURY
54699	UNLISTED LAPAROSCOPY PROCEDURE, TESTIS
55559	UNLISTED LAPAROSCOPY PROCEDURE, SPERMATIC CORD
55706	BIOPSIES, PROSTATE, NEEDLE, TRANSPERINEAL, STEREOTACTIC TEMPLATE GUIDED SATURATION SAMPLING, INCLUDING IMAGING GUIDANCE
55860	EXPOSURE OF PROSTATE, ANY APPROACH, FOR INSERTION OF RADIOACTIVE SUBSTANCE
55862	EXPOSURE OF PROSTATE, ANY APPROACH, FOR INSERTION OF RADIOACTIVE SUBSTANCE; WITH LYMPH NODE BIOPSY(S) (LIMITED PELVIC



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

55865	EXPOSURE OF PROSTATE, ANY APPROACH, FOR INSERTION OF RADIOACTIVE SUBSTANCE; WITH BILATERAL PELVIC LYMPHADENECTOMY, INC
55873	CRYOSURGICAL ABLATION OF THE PROSTATE
55875	TRANSPERINEAL PLACEMENT OF NEEDLES OR CATHETERS INTO PROSTATE FOR INTERSTITIAL RADIOELEMENT APPLICATION, W/WO CYSTOSCOPY
55899	UNLISTED PROCEDURE, MALE GENITAL SYSTEM
55920	PLACEMENT OF NEEDLES OR CATHETERS INTO PELVIC ORGNSAND/OR GENITALIA FOR SUBSQNT INTSTIAL RADIOLMNT APPL
56800	PLASTIC REPAIR OF INTROITUS
56805	CLITEROPLASTY FOR ADRENOGENITAL SYNDROME
56810	PERINEOPLASTY, REPAIR OF PERINEUM, NON-OBSTETRICAL (SEPARATE PROCEDURE)
57155	INSERTION OF UTERINE TANDEMA AND/OR VAGINAL OVIDS FOR CLINICAL BRACHY THERAPY
57156	INSERTION OF A VAGINAL RADIATION AFTERLOADING APPARATUS FOR CLINICAL BRACHY THERAPY
57291	CONSTRUCTION OF ARTIFICIAL VAGINA; WITHOUT GRAFT
57292	CONSTRUCTION OF ARTIFICIAL VAGINA; WITH GRAFT
57335	VAGINOPLASTY FOR ADRENOGENITAL SYNDROME
58346	INSERTION OF HEYMAN CAPSULES FOR CLINICAL BRACHY THERAPY
58578	UNLISTED LAPAROSCOPY PROCEDURE, UTERUS
58579	UNLISTED HYSTEROSCOPY PROCEDURE, UTERUS
58679	UNLISTED LAPAROSCOPY PROCEDURE, OVIDUCT, OVARY
58999	UNLISTED PROCEDURE, FEMALE GENITAL SYSTEM (NONOBSTETRICAL)
59076	FETAL SHUNT PLACEMENT, INCLUDING ULTRASOUND GUIDANCE
59897	UNLISTED FETAL INVASIVE PROCEDURE, INCLUDI
59898	UNLISTED LAPAROSCOPY PROCEDURE, MATERNITY CARE
59899	UNLISTED PROCEDURE, MATERNITY CARE AND DELIVERY
60659	UNLISTED LAPAROSCOPY PROCEDURE, ENDOCRINE SYSTEM
60699	UNLISTED PROCEDURE, ENDOCRINE SYSTEM
61215	INSERTION INFUSION SYSTEM/VENTRICULAR CATH
61630	BALLOON ANGIOPLASTY/INTRACRANIAL
61635	PLACEMENT/INTRAVASC.STENT/INTRACRANIAL
61640	BALLOON DILATION INTRACRANIAL SPASM
61641	BALLOON DILATION, EACH ADDL VESSEL/SAME VASCULAR FAMILY
61642	BALLOON DILATION, EACH ADDL VESSEL/DIFFERENT VASCULAR FAM.
61720	CREATION OF LESION/STEREOTACTIC METHOD
61791	CREATION OF LESION BY STEREOTACTIC METHOD, PERCUTANEOUS, BY NEUROLYTIC AGENT (EG, ALCOHOL, THERMAL, ELECTRICAL, RADIOFR
61796	STEREOTATIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); 1 SIMPLE CRANIAL LESION
61797	; EACH ADDITIONAL CRANIAL LESION, SIMPLE
61798	; 1 COMPLEX CRANIAL LESION
61799	; EACH ADDITIONAL CRANIAL LESION, COMPLEX
61800	APPLICATION OF STEREOTACTIC HEADFRAME FOR STEREOTACTIC RADIOSURGERY



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

61863	TWIST DRILL, BURR HOLE, CRANIOTOMY, IMPLANT NEUROSTIMULATOR ELECTRODE ARRAY W/O USE OF INTRAOPERATIVE MICROELECTRODE RECORDING
61864	TWIST DRILL, BURR HOLE, CRANIOTOMY, EACH ADDITIONAL ARRAY
61867	TWIST DRILL, BURR HOLE, CRANIOTOMY, IMPLANT NEUROSTIMULATOR ELECTRODE ARRAY WITH USE OF INTRAOPERATIVE MICROELECTRODE RECORDING
61868	TWIST DRILL, BURR HOLE, CRANIOTOMY, EACH ADDITIONAL ARRAY
61870	CRANIECTOMY/CORTICAL FOR ELECTRODES
61875	CRANIECTOMY/SUBCORTICAL FOR ELECTRODES
61885	INSERTION OR REPLACEMENT OF CRANIAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER
61886	INCISION AND SUBCUTANEOUS PLACEMENT OF CRANIAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER
62263	PERCUTANEOUS LYSIS OF EPIDURAL ADHESIONS USING SOLUTION INJ
62264	PERCUTANEOUS LYSIS OF EPIDURAL ADHESIONS USING SOLUTION INJ
62282	INJECTION OF NEUROLYTIC SUBSTANCE, LUMBAR OR CAUDAL EPIDURAL
62287	ASPIRATION PROCEDURE, PERCUTANEOUS, OF NUCLEUS PULPOSUS
62290	INJECTION PROCEDURE FOR DISKOGRAPHY, EACH LEVEL;LUMBAR
62291	INJECTION PROCEDURE FOR DISKOGRAPHY, EACH LEVEL;CERVICAL
62292	INJECTION PROCEDURE FOR CHEMONUCLEOLYSIS, INCLUDING DISKOGRAPHY, INTERVERTEBRAL DISK, SINGLE OR MULTIPLE LEVELS, LUMBAR
62350	EPIDURAL OR INTRATHECAL CATHETER IMPLANT/REVISION W/O LAMINECTOMY
62351	EPIDURAL OR INTRATHECAL CATHETER IMPLANT/REVISION WITH LAMINECTOMY
62360	IMPLANT SUBCUTANEOUS RESERVOIR FOR EPIDURAL DRUG INFUSION
62361	IMPLANT SUBCUTANEOUS RESERVOIR FOR EPIDURAL DRUG INFUSION W/NON PROGRAMMABLE PUMP
62362	IMPLANT SUBCUTANEOUS RESERVOIR FOR EPIDURAL DRUG INFUSION W/PROGRAMMABLE PUMP
63005	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF SPINAL CORD AND/OR CAUDA EQUINA, WITHOUT FACETECTOMY, FORAMINOTOMY (Remove Spinal Lamina)
63012	LAMINECTOMY WITH REMOVAL OF ABNORMAL FACETS AND/OR PARS INTER-ARTICULARIS WITH DECOMPRESSION OF CAUDA EQUINA (Remove Spinal Lamina)
63017	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF SPINAL CORD AND/OR CAUDA EQUINA, WITHOUT FACETECTOMY, FORAMINOTOMY (Remove Spinal Lamina)
63020	LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINOTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC, INCLUDING OPEN AND ENDOSCOPICALLY-ASSISTED APPROACHES; 1 INTERSPACE, CERVICAL
63030	LAMINOTOMY (HEMILAMINECTOMY), W/ DECOMPRESSION NERVE ROOT(S) INCLUDING PARTIAL FACETECTOMY FORAMINOTOMY (Low Back Disk Surgery)
63035	LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINOTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC, INCLUDING OPEN AND ENDOSCOPICALLY-ASSISTED APPROACHES; EACH ADDITIONAL INTERSPACE, CERVICAL OR LUMBAR (LIST SEPARATELY IN ADDITION TO



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

	CODE FOR PRIMARY PROCEDURE)
63042	LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINOTOMY (Low Back Disk Surgery)
63047	LAMINECTOMY, FACETECTOMY AND FORAMINOTOMY (UNILATERAL OR BILATERAL WITH DECOMPRESSION OF SPINAL CORD, CAUDA EQUINA (Remove Spinal Lamina)
63056	TRANSPEDICULAR APPROACH WITH DECOMPRESSION OF SPINAL CORD, EQUINA AND/OR NERVE ROOT(S) (EG, HERNIATED INTERVERTEBRAI (Decompress Spinal Cord )
63090	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),
63091	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION),
63620	STEREOTATIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); 1 SPINAL LESION
63621	; EACH ADDITIONAL SPINAL LESION
63650	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; EPIDURAL
63655	LAMINECTOMY/IMPLANT OF NEUROSTIMULATOR ELECTRODES; EPIDURAL
63685	INSERTION OR REPLACEMENT OF SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING
64520	INJECTION, ANESTHETIC AGENT; LUMBAR OR THORACIC (PARAVERTEBRAL SYMPATHETIC)
64553	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; CRANIAL NERVES
64555	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES;
64561	PERCUTANEOUS IMPLANTATION OF NERUOSTIMULATOR ELECTRODES: SACRAL NERVES
64566	POSTERIOR TIBIAL NEUROSTIMULATION, PERCUTANEOUS NEEDLE ELECTRODE, SINGLE TREATMENT, INCLUDES PROGRAMMING
64568	INCISION FOR IMPLANTATION OF CRANIAL NERVE (EG, VAGUS NERVE) NEUROSTIMULATOR ELECTRODE ARRAY AND PULSE GENERATOR
64569	REVISION OR REPLACEMENT OF CRANIAL NERVE (EG, VAGUS NERVE) NEUROSTIMULATOR ELECTRODE ARRAY, INCLUDING CONNECTION TO EXISTING PULSE GENERATOR
64575	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; PERIPHERAL NERVE
64581	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; SACRAL NERVES
64590	INSERT OR REPLACE OF PERIPHERAL OR GASTRIC NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING
64595	REVISION OR REMOVAL OF PERIPHERAL OR GASTRIC NEUROSTIMULATOR
64600	DESTRUCTION BY NEUROLYTIC AGENT, TRIGEMINAL NERVE; SUPRAORBITAL
64605	DESTRUCTION BY NEUROLYTIC AGENT, TRIGEMINAL NERVE; SECOND AND THIRD DIVISION BRANCHES AT FORAMEN OVALE
64610	DESTRUCTION BY NEUROLYTIC AGENT, TRIGEMINAL NERVE; SECOND AND THIRD DIVISION BRANCHES AT FORAMEN OVALE UNDER RADIOLOGIC
64611	CHEMODENERVATION OF PAROTID AND SUBMANDIBULAR SALIVARY GLANDS, BILATERAL
64612	CHEMODENERVATION OF MUSCLE(S);MUSCLE(S) INNERVATED BY FACIAL NERVE
64613	CHEMODENERVATION OF MUSCLE(S); NECK
64614	CHEMODENERVATION OF MUSCLE; CERVICAL SPINE MUSCLE
64622	DESTRUCTION BY NEUROLYTIC AGENT; PARAVERTEBRAL FACET JOINT NERVE, LUMBAR, SINGLE LEVEL
64623	DESTRUCTION BY NEUROLYTIC AGENT, LUMBAR OR SACRAL, ADDL LEVEL



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

64626	DESTRUCTION BY NEUROLYTIC AGENT; CERVICAL OR THORACIC, SINGLE LEVEL
64627	DESTRUCTION BY NEUROLYTIC AGENT, CERVICAL OR THORACIC, ADDL LEVEL
64640	DESTRUCTION BY NEUROLYTIC AGENT; OTHER PERIPHERAL NERVE OR BRANCH
64650	CHEMODENERVATION OF ECCRINE GLANDS; BOTH AXILLAE
64653	CHEMODENERVATION OF OTHER AREA(S), PER DAY
64714	NEUROPLASTY, MAJOR PERIPHERAL NERVE, ARM OR LEG; LUMBAR PLEXUS
64716	NEUROPLASTY AND/OR TRANSPOSITION; CRANIAL NERVE (SPECIFY)
64722	DECOMPRESSION; UNSPECIFIED NERVE(S) (SPECIFY)
64732	TRANSECTION OR AVULSION OF; SUPRAORBITAL NERVE
64734	TRANSECTION OR AVULSION OF; INFRAORBITAL NERVE
64736	TRANSECTION OR AVULSION OF; MENTAL NERVE
64738	TRANSECTION OR AVULSION OF; INFERIOR ALVEOLAR NERVE BY OSTEOTOMY
64740	TRANSECTION OR AVULSION OF; LINGUAL NERVE
64742	TRANSECTION OR AVULSION OF; FACIAL NERVE, DIFFERENTIAL OR COMPLETE
64864	SUTURE OF FACIAL NERVE; EXTRACRANIAL
64865	SUTURE OF FACIAL NERVE; INTRATEMPORAL, WITH OR WITHOUT GRAFTING
64866	ANASTOMOSIS; FACIAL-SPINAL ACCESSORY
64868	ANASTOMOSIS; FACIAL-HYPOGLOSSAL
64870	ANASTOMOSIS; FACIAL-PHRENIC
64999	UNLISTED PROCEDURE, NERVOUS SYSTEM
65756	KERATOPLASTY (CORNEAL TRANSPLANT); ENDOTHELIAL
65757	BACKBENCH PREPARATION OF CORNEAL ENDOTHELIAL ALLOGRAFT PRIO TO TRANSPLANTATION
65760	KERATOMILEUSIS
65765	KERATOPHAKIA
65767	EPIKERATOPLASTY
65770	KERATOPROSTHESIS
65771	RADIAL KERATOTOMY
65772	CORNEAL RELAXING INCISION FOR CORRECTION OF SURGICALLY INDUCED ASTIGMATISM
65775	CORNEAL WEDGE RESECTION FOR CORRECTION OF SURGICALLY INDUCED
66174	TRANSLUMINAL DILATION OF AQUEOUS OUTFLOW CANAL; WITHOUT RETENTION OF DEVICE OR STENT
66175	TRANSLUMINAL DILATION OF AQUEOUS OUTFLOW CANAL; WITH RETENTION OF DEVICE OR STENT
66840	REMOVAL OF LENS MATERIAL; ASPIRATION TECHNIQUE, ONE OR MORE STAGES
66850	REMOVAL OF LENS MATERIAL; PHACOFRAGMENTATION TECHNIQUE (MECHANICAL OR ULTRASONIC) (EG, PHACOEMULSIFICATION)
66852	REMOVAL OF LENS MATERIAL; PARS PLANA APPROACH, WITH OR WITHOUT VITRECTOMY
66920	REMOVAL OF LENS MATERIAL; INTRACAPSULAR
66930	REMOVAL OF LENS MATERIAL; INTRACAPSULAR, FOR DISLOCATED LENS
66940	REMOVAL OF LENS MATERIAL; EXTRACAPSULAR (OTHER THAN 66840, 66850, 66852)
66982	EXTRACAPSULAR CATARACT REMOVAL W/INSERTION OF INTRAOCULAR LENS PROSTHESIS,MANUAL OR MECHANICAL TECHNIQUE



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

66983	INTRACAPSULAR CATARACT EXTRACTION WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (ONE STAGE PROCEDURE)
66984	EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR
66985	INSERTION OR EXCHANGE OF INTRAOCULAR LENS PROSTHESIS (SECONDARY IMPLANT) NOT ASSOCIATED WITH CONCURRENT CATARACT REMOVA
66999	UNLISTED PROCEDURE, ANTERIOR SEGMENT OF EYE
67027	INPLANTATION OR REPLACEMENT OF INTRAVITREAL DRUG DELIVERY SYSTEM
67028	STEM (EG,GANCICIOVIR IMPLANT),INCLUDES CONCOMITANT REMOVAL
67218	DESTRUCTION OF LOCALIZED LESION OF RETINA (EG, MACULOPATHY, CHOROIDOPATHY, SMALL TUMORS), ONE OR MORE SESSIONS
67220	DESTRUCTION OF LOCALIZED OF CHOROID (EG, CHOROIDAL NEOVASCU)ONE OR MORE SESSION , PHOTOCOAGULATION (LASER)
67299	UNLISTED PROCEDURE, POSTERIOR SEGMENT
67345	CHEMODENERVATION OF EXTRAOCULAR MUSCLE
67399	UNLISTED PROCEDURE, OCULAR MUSCLE
67599	UNLISTED PROCEDURE, ORBIT
67900	REPAIR OF BROW PTOSIS (SUPRACILIARY, MID-FOREHEAD OR CORONAL APPROACH)
67901	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE
67902	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE
67903	REPAIR OF BLEPHAROPTOSIS; (TARSO)LEVATOR RESECTION OR ADVANCEMENT, INTERNAL APPROACH
67904	REPAIR OF BLEPHAROPTOSIS;
67906	REPAIR OF BLEPHAROPTOSIS; SUPERIOR RECTUS TECHNIQUE WITH FACIAL SLING (INCLUDES OBTAINING FASCIA)
67908	REPAIR OF BLEPHAROPTOSIS; CONJUNCTIVO-TARSO-LEVATOR RESECTION
67916	REPAIR OF ECTROPION; EXCISION TARSAL WEDGE
67917	REPAIR OF ECTROPION; <i>EXTENSIVE</i>
67923	REPAIR OF ENTROPION; <i>excision tarsal wedge</i>
67999	UNLISTED PROCEDURE, EYELIDS
68399	UNLISTED PROCEDURE, CONJUNCTIVA
68899	UNLISTED PROCEDURE, LACRIMAL SYSTEM
69300	OTOPLASTY, PROTRUDING EAR, WITH OR WITHOUT
69399	UNLISTED PROCEDURE, EXTERNAL EAR
69710	IMPLANT BONE CONDUCTION HEARING DEVICE
69714	OSSEOINTEGRATED IMPLANT W/ATTACHMENT TO EXTERNAL SPEECH PROCESSOR
69715	OSSEOINTEGRATED IMPLANT W/ATTACHMENT TO EXTERNAL SPEECH PROCESSOR, WITH MASTOIDECTOMY
69717	REPLACEMENT OF OSSEOINTEGRATED IMPLANT
69718	REPLACEMENT OF OSSEOINTEGRATED IMPLANT, WITH MASTOIDECTOMY
69799	UNLISTED PROCEDURE, MIDDLE EAR
69930	COCHLEAR DEVICE IMPLANTATION, WITH OR WITH
69949	UNLISTED PROCEDURE, INNER EAR
69955	TOTAL FACIAL NERVE DECOMPRESSION AND/OR REPAIR (MAY INCLUDE GRAFT)



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

69979	UNLISTED PROCEDURE, TEMPORAL BONE, MIDDLE FOSSA
70554	MRI, BRAIN, FUNCTIONAL MRI;
70555	MRI, BRAIN, FUNCTIONAL MRI;
71250	COMPUTED TOMOGRAPHY, THORAX; W/O CONTRAST
71260	CT THORAX, WITH CONTRAST MATERIAL
71270	CT THORAX, WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL
72159	MAGNETIC RESONANCE ANGIOGRAPHY, SPINAL CANAL AND CONTENTS, WITH OR WITHOUT CONTRAST MATERIAL(S)
72285	DISKOGRAPHY, CERVICAL; SUPERVISION AND INTERPRETATION ONLY
72291	RADIOLOGICAL SUPERVISION AND INTERPRETATION, PERQ VERTEBROPLASTY/VERTEBRAL AUGMENTATION
72292	RADIOLOGICAL SUPERVISION AND INTERPRETATION, PERQ VERTEBROPLASTY/VERTEBRAL AUGMENTATION
73221	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF UPPER EXTREMITY
73222	MAGNETIC RESONANCE IMAGING, ANY JOINT OF UPPER EXTREMITY; WITH CONTRAST MATERIALS
73223	MAGNETIC RESONANCE IMAGING, ANY JOINT OF UPPER EXTREMITY; W/O CONTRAST, FOLLOWED CONTRAST, AND FURTHER SEQUENCES
73721	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF LOWER EXTREMITY; WITHOUT CONTRAST MATERIALS
73722	MAGNETIC RESONANCE IMAGING, ANY JOINT OF LOWER EXTREMITY; WITH CONTRAST MATERIALS
73723	MAGNETIC RESONANCE IMAGING, ANY JOINT OF LOWER EXTREMITY W/O CONTRAST, FOLLOWED CONTRAST AND FURTHER SEQUENCES
74261	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC
74262	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC
74263	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, SCREENING, INCLUDING IMAGE POSTPROCESSING
75571	COMPUTED TOMOGRAPHY, HEART, WITHOUT CONTRAST MATERIAL
75574	CT ANGIOGRAPHY, HEART, CORONARY ARTERIES AND BYPASS GRAFTS
75894	TRANSCATHETER THERAPY, EMBOLIZATION (EG, P
75952	ENDOVASCULAR REPAIR OF INFRARENAL ABDOMINAL AORTIC ANEURYSM OR DISSECTION, RADIOLOGICAL SUPERVISION AND INTERPRETATION
75953	PLACEMENT OF PROXIMAL OR DISTAL EXTENSION PROSTHESIS, RADIO SUPV & INTERP, FOR ENDOVASCULAR REPAIR OF INFRARENAL AORTIC
75956	RADIOLOGICAL SUPERVISION AND INTERPRETATION FOR ENDOVASCULAR
75957	RADIOLOGICAL SUPERVISION AND INTERPRETATION FOR ENDOVASCULAR REPAIR OF DESCENDING THORACIC AORTA; NOT INVOLVING COVERAG
75958	RADIOLOGICAL SUPERVISION AND INTERPRETATION FOR THE PLACEMENT OF PROXIMAL EXTENSION PROSTHESIS FOR ENDOVASCULAR REPAIR
75959	RADIOLOGICAL SUPERVISION AND INTERPRETATION FOR THE PLACEMENT OF DISTAL EXTENSION PROSTHESIS FOR ENDOVASCULAR REPAIR OF
76120	CINERADIOGRAPHY, EXCEPT WHERE SPECIFICALLY INCLUDED



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

76125	CINERADIOGRAPHY TO COMPLEMENT ROUTINE EXAMINATION
76376	3D RENDERING WITH INTERPRETATION AND REPORTING OF COMPUTED TOMOGRAPHY, MAGNETIC RESONANCE IMAGING, ULTRASOUND, OR OTHER
76377	3D RENDERING WITH INTERPRETATION AND REPORTING OF COMPUTED TOMOGRAPHY, MAGNETIC RESONANCE IMAGING, ULTRASOUND, OR OTHER
76390	MAGNETIC RESONANCE SPECTROSCOPY
76496	UNLISTED FLUOROSCOPIC PROCEDURE
76497	UNLISTED COMPUTED TOMOGRAPHY PROCEDURE
76498	UNLISTED MAGNETIC RESONANCE PROCEDURE
76499	UNLISTED DIAGNOSTIC RADIOGRAPHIC PROCEDURE
76873	ECHOGRAPHY, TRANSRECTAL; PROSTATE VOLUME STUDY FOR BRACHYTHERAPY TREATMENT PLANNING
76940	ULTRASOUND GUIDE PARENCHYMAL TISSUE ABLATION
76965	ULTRASONIC GUIDANCE FOR INTERSTITIAL RADIOELEMENT APPLICATION
76977	ULTRASOUND BONE DENSITY MEASUREMENT AND INTERPRERATION, PERIPHERAL SITE(S) ANY METHOD
76999	UNLISTED ULTRASOUND PROCEDURE
77013	COMPUTERIZED TOMOGRAPHY GUIDANCE FOR, AND MONITORING OF , PARENCHYMAL TISSUE ABLATION.
77022	MAGNETIC RESONANCE GUIDANCE FOR, AND MONITORING OF , PARENCHYMAL TISSUE ABLATION.
77058	MRI, BREAST, W/WO CONTRAST, UNILATERAL
77059	MRI, BREAST, W/WO CONTRAST, BILATERAL
77079	COMPUTED TOMOGRAPHY , BONE MINERAL DENSITY STUDY, 1 OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (EG, RADIUS, WRIST
77081	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL)
77083	RADIOGRAPHIC ABSORPTIOMETRY (EG, PHOTODENSITOMETRY, RADIOGRAMMETRY), 1 OR MORE SITES
77084	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BONE MARROW BLOOD SUPPLY
77299	UNLISTED PROCEDURE, THERAPEUTIC RADIOLOGY CLINICAL
77301	INTENSITY MODULATED RADIOTHERAPY PLAN
77326	BRACHYTHERAPY ISODOSE PLAN; SIMPLE (CALC MADE FROM SINGLE PLANE, 1-4 SOURCES/RIBBON APPL,REMOTE AFTERLOADING1-8SOURCE
77327	BRACHYTHERAPY ISODOSE CALCULATION; INTERMEDIATE (MULTIPLANE DOSAGE CALCULATIONS, APPLICATION INVOLVING FIVE T
77328	BRACHYTHERAPY ISODOSE CALCULATION; COMPLEX (MULTIPLANE ISODOSE PLAN, VOLUME IMPLANT CALCULATIONS, OVER TEN SOURCES/RIB
77338	MULTI-LEAF COLLIMATOR (MLC) DEVICE(S) FOR INTENSITY MODULATE D RADIATION THERAPY (IMRT), DESIGN AND CONSTRUCTION PER IMRT
77371	RADIATION TX DELIVERY, STEREOTACTIC RADIOSURGERY, COMPLETE COURSE OF TX OF CEREBRAL LESION(S) CONSISTING OF 1 SESSION;
77372	RADIATION TX DELIVERY, STEREOTACTIC RADIOSURGERY, COMPLETE COURSE OF TX OF



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

	CEREBRAL LESION(S) CONSISTING OF 1 SESSION;
77373	STEREOTACTIC BODY RADIATION TX, TX DELIVERY, PER FRACTION
77399	UNLISTED PROCEDURE, MEDICAL RADIATION PHYSICS, DOS
77418	INTENSITY MODULATED TREATMENT DELIVERY
77422	HIGH ENERGY NEUTRON RADIATION TREATMENT DELIVERY; SINGLE TREATMENT AREA USING A SINGLE PORT OR PARALLEL-OPPOSED PORTS
77423	HIGH ENERGY NEUTRON RADIATION TREATMENT DELIVERY; ONE OR MORE ISOCENTER(S) WITH COPLANAR OR NON-COPLANAR GEOMETRY
77432	STEREOTACTIC RADIATION TX OF CEREBRAL LESION
77435	STEREOTACTIC BODY RADIATION TX, TX MANAGEMENT, PER TX COURSE, TO ONE OR MORE LESIONS, ENTIRE COURSE NOT TO EXCEED 5 FRAC
77499	UNLISTED PROCEDURE, THERAPEUTIC RADIOLOGY CLINICAL
77520	PROTON TREATMENT DELIVERY;SIMPLE,WITHOUT COMPENSATION
77522	PROTON TREATMENT DELIVERY; SIMPLE WITH COMPENSATION
77523	PROTON TREATMENT DELIVERY; SIMPLE,WITHOUT COMPENSATION, INTERMEDIATE
77525	PROTON TREATMENT DELIVERY; COMPLEX
77600	HYPERTHERMIA, EXTERNALLY GENERATED, SUPERFICIAL
77605	HYPERTHERMIA, EXTERNALLY GENERATED; DEEP
77610	HYPERTHERMIA GENERATED BY INTERSTITIAL PROBE
77615	HYPERTHERMIA GENERATED BY INTERSTITIAL, MORE THAN 5 INTERSTITIAL APPLICATORS
77620	HYPERTHERMIA GENERATED BY INTRACAVITARY PROBE
77761	INTRACAVITARY RADIOELEMENT RADIATION SOURCE APPLICATION; SIMPLE
77762	INTRACAVITARY RADIOELEMENT APPLICATION; INTERMEDIATE
77763	INTRACAVITARY RADIOELEMENT APPLICATION; COMPLEX
77776	INTERSTITIAL RADIOELEMENT RADIATION SOURCE APPLICATION;
77777	INTERSTITIAL RADIOELEMENT APPLICATION; INTERMEDIATE
77778	INTERSTITIAL RADIOELEMENT APPLICATION; COMPLEX
77785	REMOTE AFTERLOADING HIGH DOSE RATE RADIONUCLIDE BRACHYTHERAPY; 1 CHANNEL
77786	REMOTE AFTERLOADING HIGH DOSE RATE RADIONUCLIDE BRACHYTHERAPY; 2-12 CHANNELS
77787	REMOTE AFTERLOADING HIGH DOSE RATE RADIONUCLIDE BRACHYTHERAPY; OVER 12 CHANNELS
77790	SUPERVISION, HANDLING, LOADING OF RADIOELEMENT
77799	UNLISTED PROCEDURE, CLINICAL BRACHYTHERAPY
78099	UNLISTED ENDOCRINE PROCEDURE, DIAGNOSTIC NUCLEAR
78199	UNLISTED HEMATOPOIETIC, RETICULOENDOTHELIAL AND LY
78205	LIVER IMAGING (SPECT)
78206	LIVER IMAGING (SPECT); WITH VASCULAR FLOW
78299	UNLISTED GASTROINTESTINAL PROCEDURE, DIAGNOSTIC
78320	LIVER IMAGING (SPECT)
78350	BONE DENSITY (BONE MINERAL CONTENT) STUDY; SINGLE PHOTON ABSORPTIOMETRY
78399	UNLISTED MUSCULOSKELETAL PROCEDURE, DIAGNOSTIC NUC
78459	MYCARDIAL IMAGING POSITRON EMISSION TOMOGRAPHY(PET) METABOLIC EVALUATION



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

78491	MYOCARDIAL IMAGING, POSITION EMISSION TOMOGRAPHY (PET) PERFUSION; SINGLE STUDY AT REST OR STRESS
78492	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET) PERFUSION; MULTIPLE STUDIES AT REST AND/OR STRESS
78599	UNLISTED RESPIRATORY PROCEDURE, DIAGNOSTIC NUCLEAR
78607	BRAIN IMAGING, COMPLETE STUDY; TOMOGRAPHIC (SPECT)
78608	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY(PET); METABOLIC EVALUATION
78609	BRAIN IMAGING,POSITRON EMISSION TOMOGRAPHY (PET); PERFUSION EVALUATION
78647	CERBROSPINAL FLUID FLOW, IMAGING; TOMOGRAPHIC
78699	UNLISTED NERVOUS SYSTEM PROCEDURE, DIAGNOSTIC NUCL
78710	KIDNEY IMAGING; TOMOGRAPHIC (SPECT)
78799	UNLISTED GENITOURINARY PROCEDURE, DIAGNOSTIC NUCLE
78803	TUMOR LOCALIZATION (SPECT)
78811	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY; LIMITED AREA
78812	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY; SKULL BASE TO MID-THIGH
78813	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY; WHOLE BODY
78814	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY WITH CONCURRENT ACQUIRED COMPUTED TOMOGRAPHY FOR ATTENUATION CORRECTION
78815	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY WITH CONCURRENT ACQUIRED COMPUTED TOMOGRAPHY FOR ATTENUATION CORRECTION
78816	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY WITH CONCURRENT ACQUIRED COMPUTED TOMOGRAPHY FOR ATTENUATION CORRECTION
78999	UNLISTED MISCELLANEOUS PROCEDURE, DIAGNOSTIC NUCLE
79403	RADIOPHARMACEUTICAL THERAPY, RADIOLABELED MONOCLONAL ANTIBODDY INTRAVENOUS INFUSION
79445	RADIOPHARMACEUTICAL THERAPY, BY INTRA-ARTERIAL PARTICULATE ADMINISTRATION
79999	UNLISTED RADIONUCLIDE THERAPEUTIC PROCEDURE
81099	UNLISTED URINALYSIS PROCEDURE
83890	MOLECULAR DIAGNOSTICS;ISOLATION OR EXTRACTION OF HIGHLY PURIFIED NUCLEIC ACID
83891	MOLECULAR DIAGNOSTICS;
83892	NUCLEAR MOLECULAR DIAGNOSTICS; ENZYMATIC DIGESTION
83893	MOLECULAR DIAGNOSTICS;DOT/SLOT BLOT PRODUCTION
83894	NUCLEAR MOLECULAR DIAGNOSTICS; SEPARATION
83896	NUCLEAR MOLECULAR DIAGNOSTICS; NUCLEIC ACID PROBE, EACH
83897	MOLECULAR DIAGNOSTICS;NUCLEIC ACID TRANSFER
83898	MOLECULAR DIAGNOSTICS; AMPLIFICATION OF PATIENT NUCLEIC ACID
83900	MOLECULAR DIAGNOSTICS; AMPLIFICATION OF PATIENT NUCLEIC ACID
83901	MOLECULAR DIAGNOSTICS; AMPLIFICATION OF PATIENT NUCLEIC ACID
83902	MOECULAR DIANOSTICS; REVERSE TRANSCRIPTION
83903	MOLECULAR DIAGNOSTICS;MUTATION SCANNING,
83904	MOLECULAR DIAGNOSTICS;MUTATION IDENTIFICATION BY SEQUENCING



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

83905	MOLECULAR DIAGNOSTICS;MUTATION IDENTIFICATION BY ALLELE SPECIFIC TRANSCRIPTION
83906	MOLECULAR DIAGNOSTIC; MUTATION IDENTIFICATION BY ALLELE SPECIFIC TRANSLATION SINGLE SEGMENT, EACH SEGMENT
83907	MOLECULAR DIAGNOSTICS; LYSIS OF CELLS PRIOR TO NUCLEIC ACID EXTRACTION
83908	MOLECULAR DIAGNOSTICS; SIGNAL AMPLIFICATION OF PATIENT NUCLEIC ACID, EACH NUCLEIC ACID SEQUENCE
83909	MOLECULAR DIAGNOSTICS; SEPARATION AND IDENTIFICATION BY HIGH RESOLUTION TECHNIQUE
83912	NUCLEIC ACID PROBE, WITH ELECTROPHORESIS
83913	MOLECULAR DIAGNOSTICS; RNA STABILIZATION
83914	MUTATION IDENTIFICATION BY ENZYMATIC LIGATION OR PRIMER EXTENSION, SINGLE SEGMENT, EACH SEGMENT
84999	UNLISTED CHEMISTRY OR TOXICOLOGY PROCEDURE
85999	UNLISTED HEMATOLOGY PROCEDURE
86001	ALLERGEN SPECIFIC IGG QUANTITATIVE OR SEMIQUANTITATIVE, EACH ALLERGEN
86343	LEUKOCYTE HISTAMINE RELEASE TEST (LHR)
86352	CELLULAR FUNCTION ASSAY INVOLVING STIMULATION (EG, MITOGEN O R ANTIGEN) AND DETECTION OF BIOMARKER (EG, ATP)
86849	UNLISTED IMMUNOLOGY
86999	UNLISTED IMMUNOLOGY PROCEDURE
87999	UNLISTED MICROBIOLOGY PROCEDURE
88199	UNLISTED CYTOPATHOLOGY PROCEDURE
88245	CHROMOSOME ANALYSIS FOR BREAKAGE SYNDROMES; SCORE 25 CELLS
88248	CHROMOSOME ANALYSIS FOR BREAKAGE SYNDROMES; SCORE 100 CELLS,
88249	CHROMOSOME ANALYSIS FOR BREAKAGE SYNDROMES;SCORE 100 CELLS, CLASTOGEN STRESS
88261	CHROMOSOME ANALYSIS; COUNT 5 CELLS, 1 KARYOTYPE, WITH BANDING
88262	CHROMOSOME ANALYSIS; COUNT 15-20 CELLS, 2 KARYOTYPES, WITH BANDING
88263	CHROMOSOME ANALYSIS; COUNT 45 CELLS FOR MOSAICISM, 2 KARYOTYPES, WITH BANDING
88264	CHROMOSOME ANALYSIS;ANALYZE 20-25 CELLS
88271	MOLECULAR CYTOGENETICS; DNA PROBE,EACH (EG FISH)
88272	MOLECULAR CYTOGENETICS; CHROMOSOMAL IN SITU HYBRIDIZATION ANALYZE 3-5 CELLS
88273	MOLECULAR CYTOGENETICS; CHROMOSOMAL IN SITU HYBRIDIZATION, ANALYZE 10-30 CELLS
88274	MOECULAR CYTOGENTICS;INTERPHASE IN SITU HYBRIDIZATION, ANALYZE 25-99 CELLS
88275	MOLECULAR CYTOGENETICS;INTERPHASE IN SITU HYBRIDIZATION ANALYZE 100-300 CELLS
88280	CHROMOSOME ANALYSIS; ADDITIONAL KARYOTYPES, EACH STUDY
88283	CHROMOSOME ANALYSIS; ADDITIONAL SPECIALIZED BANDING TECHNIQUE (EG, NOR, C-BANDING)
88285	CHROMOSOME ANALYSIS; ADDITIONAL CELLS COUNTED, EACH STUDY
88289	CHROMOSOME ANALYSIS; ADDITIONAL HIGH RESOLUTION STUDY



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

88291	CYTOGENETICS AND MOLECULAR CYTOGENETICS, INTERPRETATION AND REPORT
88299	UNLISTED CYTOGENETIC STUDY
88356	MORPHOMETRIC ANALYSIS; NERVE
88363	EXAMINATION AND SELECTION OF RETRIEVED ARCHIVAL (IE, PREVIOUSLY DIAGNOSED) TISSUE(S) FOR MOLECULAR ANALYSIS (EG, KRAS MUTATIONAL ANALYSIS)
88384	ARRAY-BASED EVALUATION OF MULTIPLE MOLECULAR PROBES; 11 THROUGH 50 PROBES
88385	ARRAY-BASED EVALUATION OF MULTIPLE MOLECULAR PROBES; 51 THROUGH 250 PROBES
88386	ARRAY-BASED EVALUATION OF MULTIPLE MOLECULAR PROBES; 251 THROUGH 500 PROBES
88399	UNLISTED SURGICAL PATHOLOGY PROCEDURE
89240	UNLISTED MISCELLANEOUS PATHOLOGY TEST
89290	BIOPSY, OOCYTE POLAR BODY OR EMBRYO BLASTOMERE
89291	BIOPSY, OOCYTE POLAR BODY OR EMBRYO BLASTOMERE, GREATER THAN 5 EMBRYOS
89344	STORAGE, (PER YEAR); REPRODUCTIVE TISSUE, TESTICULAR/OVARIAN
89346	STORAGE, (PER YEAR); OOCYTE(S)
89354	THAWING OF CRYOPRESERVED; REPRODUCTIVE TISSUE, TESTICULAR/OVARIAN
89356	THAWING OF CRYOPRESERVED; OOCYTES, EACH ALIQUOT
89398	UNLISTED REPRODUCTIVE MEDICINE LABORATORY PROCEDURE
90281	IMMUNE GLOBULIN (IG) HUMAN FOR INTRAMUSCULAR USE
90283	IMMUNOGLOBULIN, IGIV
90284	IMMUNE GLOBULIN, HUMAN, FOR USE IN SUBCUTANEOUS INFUSION,100 MG,EACH
90378	RESPIRATORY SYNCYTIAL VIRUS IMMUNE GLOBULIN, FOR INTRAMUSCULAR USE, 50MG, EACH
90399	UNLISTED IMMUNE GLOBULIN
90749	UNLISTED IMMUNIZATION PROCEDURE
90779	UNLISTED THERAPEUTIC, PROPHYLACTIC OR DIA
90804	INDIVIDUAL PSYCHOTHERAPY,INSIGHT ORIENTED,BEHAVIOR MODIFYING
90805	INDIVIDUAL PSYCHOTHERAPY,INSIGHT ORIENTED,BEHAVIOR MODIFYING
90806	INDIVIDUAL PSYCHOTHERAPY,INSIGHT ORIENTED,BEHAVIOR MODIFYING
90807	INDIVIDUAL PSYCHOTHERAPY,INSIGHT ORIENTED,BEHAVIOR MODIFYING
90808	INDIVIDUAL PSYCHOTHERAPY,INSIGHT ORIENTED,BEHAVIOR MODIFYING
90809	INDIVIDUAL PSYCHOTHERAPY,INSIGHT ORIENTED,BEHAVIOR MODIFYING
90810	INDIVIDUAL PSYCHOTHERAPY,INTERACTIVE,
90811	INDIVIDUAL PSYCHOTHERAPY,INTERACTIVE
90812	INDIVIDUAL PSYCHOTHERAPY,INTERACTIVE
90813	INDIVIDUAL PSYCHOTHERAPY,INTERACTIVE
90814	INDIVIDUAL PSYCHOTHERAPY,INTERACTIVE
90815	INDIVIDUAL PSYCHOTHERAPY,INTERACTIVE
90816	INDIVIDUAL PSYCHOTHERAPY,INSIGHT ORIENTED BEHAVIOR INPATIENT
90817	INDIVIDUAL PSYCHOTHERAPY INSIGHT ORIENTED BEHAVIOR MODIFYING
90818	INDIVIDUAL PSYCHOTHERAPY INSIGHT ORIENTED
90819	INDIVIDUAL PSYCHOTHERAPY INSIGHT INPATIENT HOSPITAL
90821	INDIVIDUAL PSYCHOTHERAPY INSIGHT, INPATIENT
90822	INDIVIDUAL INSIGHT ORIENTED INPATIENT HOSPITAL



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

90823	INDIVIDUAL PSYCHOTHERAPY INTERACTIVE, INPATIENT HOSPITAL
90824	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, INPATIENT HOSPITAL
90826	INDIVIDUAL PSYCHOTHERAPY INTERACTIVE IN INPATIENT HOSPITAL
90827	INDIVIDUAL PSYCHOTHERAPY INTERACTIVE IN INPATIENT HOSPITAL
90828	INDIVIDUAL PSYCHOTHERAPY INSIGHTINPATIENT HOSPITAL
90829	INDIVIDUAL PSYCHOTHERAPY INTERACTIVE INPATIENT HOSPITAL
90846	FAMILY MEDICAL PSYCHOTHERAPY (WITHOUT THE PATIENT PRESENT)
90847	FAMILY MEDICAL PSYCHOTHERAPY (CONJOINT PSYCHOTHERAPY)
90849	MULTIPLE-FAMILY GROUP MEDICAL PSYCHOTHERAPY BY A PHYSICIAN
90853	GROUP MEDICAL PSYCHOTHERAPY
90857	INTERACTIVE GROUP MEDICAL PSYCHOTHERAPY
90862	PHARMACOLOGIC MANAGEMENT, INCLUDING PRESCRIPTION, USE, AND REVIEW OF MEDICATION
90867	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION TREATMENT; PLANNING
90868	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION TREATMENT; DELIVERY AND MANAGEMENT, PER SESSION
90899	UNLISTED PSYCHIATRIC SERVICE OR PROCEDURE
90901	BIOFEEDBACK, ANY MODALITY
90911	BIOFEEDBACK TRAINING, PERINEAL MUSCLES
90999	UNLISTED DIALYSIS PROCEDURE, IN HOSPITALIZ
91034	ESOPHAGUS, GASTROESOPHAGEAL REFLUX TEST;
91035	ESOPHAGUS, GASTROESOPHAGEAL REFLUX TEST;
91037	ESOPHAGEAL FUNCTION TEST, GASTROESOPHAGEAL
91038	ESOPHAGEAL FUNCTOIN TEST, GASTROESOPHAGEAL
91110	GASTROINTESTINAL TRACT IMAGING, INTRALUMIN
91111	GI TRACT IMAGING, INTRALUMINAL (EG, CAPSULE ENDOSCOPY), ESOPHAGUS WITH PHYSICIAN INTERPRETATION AND REPORT
91299	UNLISTED DIAGNOSTIC GASTROENTEROLOGY PROCEDURE
92132	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, ANTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL
92133	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, POSTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL
92134	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, POSTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL
92499	UNLISTED OPHTHALMOLOGICAL SERVICE OR PROCEDURE
92506	EVALUATION OF SPEECH, LANGUAGE, VOICE, COMMUNICATION
92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION
92508	SPEECH, LANGUAGE OR HEARING THERAPY, WITH CONTINUING MEDICAL SUPERVISION; GROUP
92700	UNLISTED OTORHINOLARYNGOLOGICAL SERVICES OR PROCED
92974	PLACEMENT DELIVERY SERVICE FOR SUBSEQUENT CORONARY INTRAVASCULAR BRACHYTHERAPY
93025	MICROVOLT T-WAVE ALTERNANS



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

93228	WEARABLE MOBILE CARDIOVASCULAR TELEMETRY WITH ELECTROCARDIOGRAPHIC RECORDING
93229	CONCURRENT COMPUTERIZED REAL TIME DATA ANALYSIS
93278	SIGNAL-AVERAGED ELECTROCARDIOGRAPHY (SAECG), WITH OR WITHOUT ECG
93580	PERCUTANEOUS TRANSCATHETER CLOSURE OF CONGENITAL INTERATRIAL COMMUNICATION WITH IMPLANT
93581	PERCUTANEOUS TRANSCATHETER CLOSURE OF A CONGENITAL VENTRICULOSEPTAL DEFECT WITH IMPLANT
93640	ELECTROPHYSIOLOGIC EVALUATION OF CARDIOVERTER-DEFIBRILLATOR LEAD AND/OR DEVICE
93641	COMPREHENSIVE ELECTROPHYSIOLOGIC EVALUATION WITH RIGHT ATRIAL PACING AND RECORDING; WITH TESTING
93642	ELECTROPHYSIOLOGIC EVAL OF DEFIBRILLATOR
93720	PLETHYSMOGRAPHY, TOTAL BODY; WITH INTERPRETATION AND REPORT
93721	PLETHYSMOGRAPHY, TOTAL BODY; TRACING ONLY, WITHOUT INTERPRETATION AND REPORT
93722	PLETHYSMOGRAPHY, TOTAL BODY; INTERPRETATION AND REPORT ONLY
93745	INITIAL SET-UP AND PROGRAMMING BY A PHYSICIAN OF WEARABLE CARDIOVERTER-DEFIBRILLATOR INCLUDES INITIAL PROGRAMMING
93799	UNLISTED CARDIOVASCULAR SERVICE OR PROCEDURE
93875	NON-INVASIVE PHYSIOLOGIC STUDIES OF EXTRACRANIAL ARTERIES, BILATERAL, (EG, PERIORBITAL FLOW DIRECTION WITH ARTERIAL
93982	NONINVASIVE PHYSIOLOGIC STUDY OF IMPLANTED WIRELESS PRESSURE SENSOR IN ANEURYSMAL SAC
94799	UNLISTED PULMONARY SERVICE OR PROCEDURE
95027	INTRACUTANEOUS (INTRADERMAL) TESTS (SPECIFY NUMBER), SEQUENTIAL & INCREMENTAL, W/ALLERGENIC EXTRACTS FOR AIRBORNE ALLERGY
95060	OPHTHALMIC MUCOUS MEMBRANE TESTS
95065	DIRECT NASAL MUCOUS MEMBRANE TEST
95199	UNLISTED ALLERGY/CLINICAL IMMUNOLOGIC SERVICE OR P
95250	AMBULATORY CONT. GLUCOSE MONITORING
95251	AMBULATORY CONT. GLUCOSE MONITORING, PHYSICIAN INTERPRETATION & REPORT
95800	SLEEP STUDY, UNATTENDED, SIMULTANEOUS RECORDING; HEART RATE, OXYGEN SATURATION, RESPIRATORY ANALYSIS (EG, BY AIRFLOW OR PERIPHERAL ARTERIAL TONE) AND SLEEP TIME
95801	SLEEP STUDY, UNATTENDED, SIMULTANEOUS RECORDING; MINIMUM OF HEART RATE, OXYGEN SATURATION, AND RESPIRATORY ANALYSIS (EG, BY AIRFLOW OR PERIPHERAL ARTERIAL TONE)
95803	ACTIGRAPHY TESTING, RECORDING, ANALYSIS, INTERPRETATION, AND REPORT (MIN OF 72 HRS TO 14 CONSECUTIVE DAYS OF RECORDING)
95805	MULTIPLE SLEEP LATENCY TESTING (MSLT), RECORDING, ANALYSIS AND INTERPRETATION OF PHYSIOLOGICAL MEASUREMENTS OF SLEEP DUR
95806	SLEEP STUDY SIMULTANEOUS RECORDING OF VENTILATION RESPIRATORY EFFORT, ECG OR HEART RATE/OXYGEN SATURATION UNATTENDED BY TECH



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

95807	SLEEP STUDY, 3 OR MORE PARAMETERS OF SLEEP OTHER THAN SLEEP STAGING, ATTENDED BY A TECHNOLOGIST
95905	MOTOR AND/OR SENSORY NERVE CONDUCTION, USING PRECONFIGURED ELECTRODE ARRAY(S)
95965	MAGNETOENCEPHALOGRAPHY (MEG),RECORDING AND
95966	MAGNETOENCEPHALOGRAPHY (MEG),RECORDING AND
95967	MAGNETOENCEPHALOGRAPHY (MEG),RECORDING AND
95972	ELECTONIC B1040ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM;COMPLEX BRAIN OR SPINAL CORD NEUROSTIMULATOR
95973	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM;COMPLEX BRAIN OR SPINAL CORD NEURO
95974	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM;COMPLEX CRANIAL NERVE NEUROSTIMULATOR
95975	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM;COMPLEX CRANIAL NERVE NEUROSTIMULATOR
95980	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM
95981	ELECTRONIC ANALYSIS OF IMPLANTED NERUOSTIMULATOR PULSE GENERATOR SYSTEM, GASTRIC NEURSTIMULATOR PULSE GENERATOR/TRANSMITTER
95982	ELECTRNIC ANALYSIS OF IMPLNTD NEUROSTIMULATOR PUSE GENERATOR SYSTEM,GASTRIC NEURSTIMULATOR PULSE GENERATOR/TRANSMITTER
95999	UNLISTED NEUROLOGICAL OR NEUROMUSCULAR DIAGNOSTIC
96020	NEUROFUNCTIONAL TEST SELECTION AND ADMINISTRATION DURING NO ININVASIVE IMAGING FUNCTIONAL BRAIN MAPPING
96365	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); INITIAL, UP TO 1 HOUR
96366	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); EACH ADDITIONAL HOUR
96367	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); ADDITIONAL SEQUENTIAL INFUSION
96368	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); CONCURRENT INFUSION
96372	THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); SUBCUTANEOUS OR INTRAMUSCULAR
96379	UNLISTED THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INTRAVENOUS OR INTRA-ARTERIAL INJECTION OR INFUSION
96549	UNLISTED CHEMOTHERAPY PROCEDURE
96900	ACTINOTHERAPY (UV LIGHT)
96904	WHOLE BODY INTEGUMENTARY PHOTOGRAPHY
96910	PHOTOCHEMOTHERAPY, TAR AND UVB
96912	PHOTOCHEMOTHERAPY, PSORALENS AND UV-PUVA
96913	PHOTOCHEMOTHERAPY, 4-8 HRS
96920	LASER TREATMENT FOR PSORIASIS< 250 SQ CM
96921	LASER TREATMENT FOR PSORIASIS > 250 SQ CM-500CM



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

96922	LASER TREATMENT FOR PSORIASIS > 500 SQ CM
96999	UNLISTED SPECIAL DERMATOLOGICAL SERVICE OR PROCEDURE
97001	PHYSICAL THERAPY EVALUATION
97002	PHYSICAL THERAPY RE-EVALUATION
97003	OCCUPATIONAL THERAPY EVALUATION
97004	OCCUPATIONAL THERAPY RE-EVALUATION
97005	ATHLETIC TRAINING AND EVALUATION
97006	ATHELETIC TRAINIG RE-EVALUATION
97010	PHYSICAL MEDICINE TREATMENT TO ONE AREA; HOT OR COLD PACKS
97012	PHYSICAL MEDICINE TREATMENT TO ONE AREA;TRACTION, MECHANICAL
97014	PHYSICAL MEDICINE TREATMENT TO ONE AREA; ELECTRICAL STIMULATION (UNATTENDED)
97016	PHYSICAL MEDICINE TREATMENT TO ONE AREA; VASOPNEUMATIC DEVICES
97018	PHYSICAL MEDICINE TREATMENT TO ONE AREA; PARAFFIN BATH
97022	PHYSICAL MEDICINE TREATMENT TO ONE AREA; WHIRLPOOL
97024	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; DIATHERMY
97026	PHYSICAL MEDICINE TREATMENT TO ONE AREA; INFRARED
97028	PHYSICAL MEDICINE TREATMENT TO ONE AREA; ULTRAVIOLET
97032	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ELECTRICAL STIMULATION(MANUAL),EACH 15 MINUTES
97033	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; IOTOPHORESIS, EACH 15 MINUTES
97034	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; CONTRAST BATHS, EACH 15 MINUTES
97035	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ULTRASOUND, EACH 15 MINUTES
97036	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; HUBBARD TANK, EACH 15 MIN
97039	PHYSICAL MEDICINE TREATMENT TO ONE AREA; UNLISTED MODALITY
97110	PHYSICAL MEDICINE TREATMENT TO ONE OR MORE AREAS, EACH 15 MINUTES;THERAPEUTIC EXERCISES TO DEVELOP STRENGTH AND ENDURANCE
97112	PHYSICAL MEDICINE TREATMENT TO ONE OR MORE AREAS EACH 15 MIN NEUROMUSCULAR REEDUCATION OF MOVEMENT, BALANCE COORDINATION
97113	TERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES AQUATIC THERAPY WITH THERAPEUTIC EXERCISES
97116	PHYSICAL MEDICINE TREATMENT TO ONE OR MORE AREAS EACH 15 MIN GAIT TRAINING
97124	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; MASSAGE, INCLUDING EFFLEURAGE,PETRISSAGE AND/OR TAPOTEMENT
97139	PHYSICAL MEDICINE TREATMENT TO ONE OR MORE AREAS EACH 15 MIN UNLISTED PROCEDURE
97140	MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION /MANIPU MANUAL LYMPHATIC DRAINAGE,MANUAL TRACTION)ONE/MORE REGIONS;EA 15 MIN
97150	THEAPEUTIC PROCEDURE(S) GROUP (2 OR MORE INDIVIDUALS)
97530	KINETIC ACTIVITIES DIRECT (ONE ON ONE) PATIENT CONTACT BY THE PROVIDER, EACH 15 MINUTES
97532	COGNITIVE SKILLS DEVELOPMENT
97535	SELF CARE/HOME MANAGEMENT TRAINING DIRECT ONE ON ONE, CONTACT BY PROVIDER



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

	EACH 15 MINUTES
97537	COMMUNITY/WORK REINTEGRATION TRAINING , DIRECT ONE-ON-ONE CONTACT BY PROVIDER, EACH 15 MINUTES
97542	WHEELCHAIR MANAGEMENT (EG, ASSESSMENT, FITTING, TRAINING), EACH 15 MINUTES
97605	NEGATIVE PRESSURE WOUND THERAPY (EG, VACUUM ASSISTED DRAINAGE COLLECTION), INCLUDING TOPICAL APPLICATION(S), WOUND ASSES
97606	WOUND CARE > 50 SQ CM
97660	WORK TOLERANCE TEST INC RPT REQ PRIOR AUTH
97670	FMCT CAPTY MEASUR, INC RPT; REQ AUTH
97680	JOB SITE VISIT; W/REPRT-PREMISS EMPLR; RE AUTH
97750	PHYSICAL PERFORMANCE TEST OR MEASUREMENT, WITH WRITTEN REPORT, EACH 15 MINUTES
97755	ASSISTIVE TECHNOLOGY ASSESSMENT, DIRECT ONE-ON-ONE CONTACT BY PROVIDER, WITH WRITTEN REPORT, EACH 15 MINUTES
97760	ORTHOTIC(S) MANAGEMENT AND TRAINING, UPPER EXTREMITY, LOWER EXTREMITY AND/OR TRUNK, EACH 15 MINUTES
97761	PROSTHETIC TRAINING, UPPER AND/OR LOWER EXTREMITY, EACH 15 MINUTES
97762	CHECKOUT FOR ORTHOTIC/PROSTHETIC USE, ESTABLISHED PATIENT, EACH 15 MINUTES
97799	UNLISTED PHYSICAL MEDICINE SERVICE OR PROCEDURE
97999	UNLISTED ACUPUNCTURE PROC
98925	OSTEOPATHIC MANIPULATIVE TREATMENT(OMT);ONE TO TWO BODY REGIONS INVOLVED
98926	OSTEOPATHIC MANIPULATIVE TREATMENT(OMT); THREE TO FOUR BODY REGIONS INVOLVED
98927	OSTEOPATHIC MANIPULATIVE TREATMENT(OMT); FIVE TO SIX BODY REGIONS
98928	OSTEOPATHIC MANIPULATIVE TREATMENT(OMT) SEVEN TO EIGHT BODY REGIONS
98929	OSTEOPATHIC MANIPULATIVE TREATMENT(OMT);NINE TO TEN BODY REGIONS INVOLVED
98940	CHIROPRACTIC MANIPULATIVE TREATMENT CMT SPINAL ONE TO TWO REGIONS
98941	CHIROPRACTIC MANIPULATIVE TREATMENT CMT SPINAL THREE TO FOUR REGIONS
98942	CHIROPRACTIC MANIPULATIVE TREATMENT CMT SPINAL FIVE REGIONS
99048	PHONE CALL PHY/LICENSE REPEAT /LENGTHY
99085	SPEC EXT MED PHOTO-DOC PROGRS
99183	HYPERBARIC TX, PHYSICIAN ATTENDANCE
99199	UNLISTED SPECIAL SERVICE OR REPORT
99429	UNLISTED PREVENTIVE MEDICINE SERVICE
99499	UNLISTED EVALUATION AND MANAGEMENT SERVICES
99600	UNLISTED HOME VISIT SERVICES OR PROCEDURE
0019T	EXTRACORPOREAL SHOCK WAVE; INVOLVING MUSCULOSKELETAL SYSTEM
0042T	CEREBRAL PERFUSION ANALYSIS USING CT
00530	ANESTHESIA FOR PACEMAKER INSERTION
00534	ANESTHESIA FOR TRANSVENOUS INSERTION OF PACING CARDIOVERTER/DEFIBRILLATOR
0054T	COMPUTER-ASSISTED MUSCULOSKELETAL SURGICAL NAVIGATIONAL ORTHOPEDIC PROCEDURE, WITH IMAGE-GUIDANCE BASED ON FLUOROSCOPIC IMAGES
0055T	COMPUTER-ASSISTED MUSCULOSKELETAL SURGICAL NAVIGATIONAL ORTHOPEDIC PROCEDURE, WITH IMAGE-GUIDANCE BASED ON CT/MRI IMAGES



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

0058T	CRYOPRESERVATION; REPRODUCTIVE TISSUE, OVARIAN
0059T	CRYOPRESERVATION; OOCYTE(S)
00622	ANESTHESIA FOR THORACOLUMBAR SYMPATHECTOMY
0071T	FOCUSED ULTRASOUND ABLATION OF UTERINE LEIOMYOMATA, VOLUME <200CC
0072T	FOCUSED ULTRASOUND ABLATION OF UTERINE LEIOMYOMATA
0073T	FOCUSED ULTRASOUND ABLATION OF UTERINE LEIOMYOMATA
00740	ANESTHESIA FOR UPPER GASTROIN-TESTINAL ENDOSCOPIC PROCEDURES
0075T	TRANSCATHETER PLACEMENT OF CAROTID ARTERY STENT, INITIAL VESSEL
0076T	TRANSCATHETER PLACEMENT OF CAROTID ARTERY STENT, EACH ADDITIONAL VESSEL
0078T	ENDOVASCULAR REPAIR USING PROSTHESIS
00796	ANESTHESIA FOR INTRAPERITONEAL PROCEDURES IN UPPER ABDOMEN INCLUDING BOWEL SHUNTS; LIVER TRANSPLANT
00797	ANESTHESIA FOR GASTRIC RESTRICTIVE PROCEDURE
0079T	PLACEMENT OF VISCERAL EXTENSION PROSTHESIS FOR ENDOVASCULAR REPAIR
00802	ANESTHESIA FOR PANNICULECTOMY
0080T	ENDOVASCULAR REPAIR, RADIOLOGICAL SUPERVISION AND INTERPRETATION
00810	ANESTHESIA FOR INTESTINAL ENDOSCOPIC PROCEDURES
0081T	PLACEMENT OF VISCERAL EXTENSION PROSTHESIS FOR ENDOVASCULAR REPAIR, RADIOLOGICAL SUPERVISION AND INTERPRETATION
0085T	BREATH TEST FOR HEART TRANSPLANT REJECTION
0092T	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), EACH ADDITIONAL SPACE
0095T	REMOVAL OF TOTAL DISC ARTHROPLASTY, ANTERIOR APPROACH, SINGLE INTERSPACE; EACH ADDITIONAL INTERSPACE
0098T	REVISION OF TOTAL DISC ARTHROPLASTY, ANTERIOR APPROACH SINGLE INTERSPACE; EACH ADDITIONAL INTERSPACE
0099T	IMPLANTATION OF INTRASTROMAL CORNEAL RING SEGMENTS
0100T	PLACEMENT OF SUBCONJUNCTIVAL RETINAL PROSTHESIS RECEIVER AND PULSE GENERATOR
0101T	EXTRACORPOREAL SHOCK WAVE INVOLVING MUSCULOSKELETAL SYSTEM
0102T	EXTRACORPOREAL SHOCK WAVE, HIGH ENERGY, PERFORMED BY A PHYSICIAN, REQUIRING ANESTHESIA OTHER THAN LOCAL
0106T	QUANTITATIVE SENSORY TESTING (QST), TESTING AND INTERPRETATION PER EXTREMITY; USING TOUCH PRESSURE STIMULI
0107T	QUANTITATIVE SENSORY TESTING (QST), TESTING AND INTERPRETATION PER EXTREMITY; USING VIBRATION STIMULI
0108T	QUANTITATIVE SENSORY TESTING (QST), TESTING AND INTERPRETATION PER EXTREMITY; USING COOLING STIMULI TO ASSESS SMALL NERVE
0109T	QUANTITATIVE SENSORY TESTING (QST), TESTING AND INTERPRETATION PER EXTREMITY; USING HEAT-PAIN STIMULI TO ASSESS SMALL NERVE
0110T	QUANTITATIVE SENSORY TESTING (QST), TESTING AND INTERPRETATION PER EXTREMITY; USING OTHER STIMULI TO ASSESS SENSATION
0123T	FISTULIZATION OF SCLERA FOR GLAUCOMA, THROUGH CILIARY BODY
0124T	CONJUNCTIVAL INCISION WITH POSTERIOR JXTASCERAL PLACEMENT OF



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

	PHARMACOLOGICAL AGENT
0126T	COMMON CAROTID IMT STUDY
0135T	CRYOABLATION RENAL TUMOR
0141T	PANCREATIC ISLET CELL TRANSPLANTATION THROUGH PORTAL VEIN
0142T	PANCREATIC ISLET CELL TRANSPLANTATION THROUGH PORTAL VEIN-OPEN
0143T	LAPAROSCOPY, SURGICAL, PANCREATIC ISLET CELL TRANSPLANTATION THROUGH PORTAL VEIN
0155T	LAPAROSCOPY, SURGICAL, IMPLANTATION OR REPLACEMENT OF GASTRIC STIMULATION ELECTRODES, LESSER CURVATURE
0156T	LAPAROSCOPY, SURGICAL, REVISION OR REMOVAL OF GASTRIC STIMULATION ELECTRODES, LESSER CURVATURE
0157T	LAPAROTOMY, IMPLANTATION OR REPLACEMENT OF GASTRIC STIMULATION ELECTRODES, LESSER CURVATURE
0158T	LAPAROTOMY, REVISION OR REMOVAL OF GASTRIC STIMULATION ELECTRODES, LESSER CURVATURE
0163T	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCL DISCECTOMY TO PREP INTERSPACE (OTHER THAN DECOMPRESS)
0164T	REMOVAL OF TOTAL DISC ARTHROPLASTY, ANTERIOR APPROACH, LUMBAR, EACH ADDITIONAL INTERSPACE
0165T	REVISION OF TOTAL DISC ARTHROPLASTY, ANTERIOR APPROACH, LUMBAR, EACH ADDITIONAL INTERSPACE
0166T	TRANSMYOCARDIAL TRANSCATHETER CLOSURE OF VENTRICULAR SEPTAL DEFECT, WITH IMPLANT; WITHOUT CARDIOPULMOMARY BYPASS
0167T	TRANSMYOCARDIAL TRANSCATHETER CLOSURE OF VENTRICULAR SEPTAL DEFECT, WITH IMPLANT; WITH CARDIOPULMONARY BYPASS
0168T	RHINOPHOTOTHERAPY, INTRANASAL APPLICATION OF ULTRAVIOLET AND VISIBLE LIGHT, BILATERAL
0169T	STEREOTACTIC PLACEMENT OF INFUSION CATHETER(S) INTHE BRAIN FOR DELIVERY OF THERAPEUTIC AGENT(S), INCLUDING COMPUTERIZED
0171T	INSERTION OF POSTERIOR SPINOUS PROCESS DISTRACTION DEVICE (INCLUDING NECESSARY REMOVAL OF BONE OR LIGAMENT FOR INSERTION
0172T	INSERTION OF POSTERIOR SPINOUS PROCESS DISTRACTION DEVICE (INC NEC REM OF BONE OR LIGAMENT FOR INSERTI & IMAGING GUIDEAN
0179T	ECG, 64 LEADS OR GREATER, W/GRAPHIC PRESENTATION; TRACING AND GRAPHICS ONLY, W/O INTERPRET AND REPORT
0180T	ECG, 64 LEADS OR GREATER, W/GRAPHIC PRESENTATION; NTERPRETATION AND REPORT ONLY
0181T	CORNEAL HYSTERESIS DETERMINATION, BY AIR IMPULSE STIMULATION, BILATERAL, W/INTERPRET AND REPORT
0182T	HIGH DOSE RATE ELECTRONIC BRACHYTHERAPY, PER FRACTION
0183T	LOW FREQUENCY, NON-CONTACT, NON-THERMAL US, INCL TOPICAL APPLICATION(S), WHEN PERFORMED, WOUND ASSESS, & INSTRUCTION(S)
0184T	EXCISION OF RECTAL TUMOR, TRANSANAL ENDOSCOPIC MICROSURGICA APPROACH (IE,



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

	TEMS)
0186T	SUPRACHOROIDAL DELIVERY OF PHARMACOLOGIC AGENT (DOES NOT INCLUDE SUPPLY OF MEDICATION)
0187T	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, ANTERIOR SEGMENT, W/INTERPRETAION & REPORT, UNILATERAL
0190T	PLACEMENT OF INTRAOCULAR RADIATION SOURCE APPLICATOR
0191T	INSERTION OF ANT SEGMENT AQUEOUS DRAINAGE DEVICE, W/O EXTRAOCULAR RESERVOIR; INTERNAL APPROACH
0192T	INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, W/O EXTRAOCULAR RESERVOIR; EXTERNAL APPROACH
0195T	ARTHRODESIS, PRE-SACRAL INTERBODY TECHNIQUE, INCLUDING INSTRUMENTATION, IMAGING (WHEN PERFORMED), AND DISCECTOMY (Lumbar Spine Fusion)
0196T	ARTHRODESIS, PRE-SACRAL INTERBODY TECHNIQUE, INCLUDING INSTRUMENTATION, IMAGING (WHEN PERFORMED), AND DISCECTOMY (Lumbar Spine Fusion)
0197T	INTRA-FRACTION LOCALIZATION AND TRACKING OF TARGET OR PATIENT MOTION DURING DELIVERY OF RADIATION THERAPY (EG, 3D POSITIONAL TRACKING, GATING, 3D SURFACE TRACKING), EACH FRACTION OF TREATMENT
0198T	MEASUREMENT OF OCULAR BLOOD FLOW BY REPETITIVE INTRAOCULAR PRESSURE SAMPLING, WITH INTERPRETATION AND REPORT
01999	UNLISTED ANESTHESIA PROCEDURE(S)
0199T	PHYSIOLOGIC RECORDING OF TREMOR USING ACCELEROMETER(S) AND/OR GYROSCOPE(S) (INCL FREQUENCY & AMPLITUDE)
0200T	PERCUTANEOUS SACRAL AUGMENTATION (SACROPLASTY), UNILATERAL INJECTION(S), INCLUDING THE USE OF A BALLOON OR MECHANICAL DE
0201T	PERCUTANEOUS SACRAL AUGMENTATION (SACROPLASTY), BILATERAL INJECTIONS, INCLUDING THE USE OF A BALLOON OR MECHANICAL DEVIC
0202T	POST VERTEBRAL JOINT(S) ARTHROPLSTY INCL FACETECTOMY, LAMINECTOMY, FORAMINOTOMY & VERTBRL COLUMN FIXATION, W/OR W/O INJE
0205T	INTRAVASCULAR CATH-BASED CORONARY VESSEL OR GRAFT SPECTROSCOPY
0206T	ALGORITHMIC ANALYSIS, REMOTE
0207T	EVACUATION OF MEIBOMIAN GLANDS, AUTOMATED, USING HEAT AND INTERMITTENT PRESSURE, UNILATERAL
0219T	PLACEMENT OF POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCL IMAGING & PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; CERVICAL
0220T	PLACEMENT OF POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCL IMAGING & PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; THORACIC
0221T	PLACEMENT OF POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; LUMBAR
0222T	PLACEMENT OF POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCL IMAGING & PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; EACH ADDITIONAL VERTEBRAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

	PROCEDURE)
0226T	ANOSCOPY, HIGH RESOLUTION (HRA) (MAGNIFICATION & CHEMICAL AGENT ENHANCEMENT); DIAGNOSTIC, INCL COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING WHEN PERFORMED
0227T	INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH ULTRASOUND GUIDANCE, LUMBAR OR SACRAL; SINGLE LEVEL
0232T	INJECTION(S), PLATELET RICH PLASMA, ANY TISSUE, INCLUDING IMAGE GUIDANCE, HARVESTING AND PREPARATION WHEN PERFORMED
0233T	SKIN ADVANCED GLYCATION ENDPRODUCTS (AGE) MEASUREMENT BY MULTI-WAVELENGTH FLUORESCENT SPECTROSCOPY
0239T	BIOIMPEDANCE SPECTROSCOPY (BIS), MEASURING 100 FREQUENCIES OR GREATER, DIRECT MEASUREMENT OF EXTRACELLULAR FLUID DIFFERENCE BETWEEN THE LIMBS
0242T	GASTROINTESTINAL TRACT TRANSIT AND PRESSURE MEASUREMENT, STOMACH THROUGH COLON, WIRELESS CAPSULE, WITH INTERPRETATION AND REPORT
0245T	OPEN TREATMENT OF RIB FRACTURE REQUIRING INTERNAL FIXATION, UNILATERAL; 1-2 RIBS
0246T	OPEN TREATMENT OF RIB FRACTURE REQUIRING INTERNAL FIXATION, UNILATERAL; 3-4 RIBS
0247T	OPEN TREATMENT OF RIB FRACTURE REQUIRING INTERNAL FIXATION, UNILATERAL; 5-6 RIBS
0248T	OPEN TREATMENT OF RIB FRACTURE REQUIRING INTERNAL FIXATION, UNILATERAL; 7 OR MORE RIBS
0250T	AIRWAY SIZING AND INSERTION OF BRONCHIAL VALVE(S), EACH LOBE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0251T	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH REMOVAL OF BRONCHIAL VALVE(S), INITIAL LOBE
0252T	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH REMOVAL OF BRONCHIAL VALVE(S), EACH ADDITIONAL LOBE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0253T	INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR; INTERNAL APPROACH, INTO THE SUPRACHOROIDAL SPACE
0256T	IMPLANTATION OF CATHETER-DELIVERED PROSTHETIC AORTIC HEART VALVE; ENDOVASCULAR APPROACH
0257T	IMPLANTATION OF CATHETER-DELIVERED PROSTHETIC AORTIC HEART VALVE; OPEN THORACIC APPROACH (EG, TRANSAPICAL, TRANSVENTRICULAR)
0258T	TRANSTHORACIC CARDIAC EXPOSURE (EG, STERNOTOMY, THORACOTOMY, SUBXIPHOID) FOR CATHETER-DELIVERED AORTIC VALVE REPLACEMENT
0259T	TRANSTHORACIC CARDIAC EXPOSURE (EG, STERNOTOMY, THORACOTOMY, SUBXIPHOID) FOR CATHETER-DELIVERED AORTIC VALVE REPLACEMENT
A0999	UNLISTED AMBULANCE SERVICE
A4257	REPLACEMENT LENS SHIELD CARTRIDGE FOR USE WITH LASER SKIN PIERCING DEVICE, EACH
A4290	SACRAL NERVE STIMULATION TEST LEAD
A4575	TOPICAL HYPERBARIC OXYGEN CHAMBER
A4638	REPLACEMENT BATTERY FOR PATIENT OWNED EAR PULSE GENERATOR
A6000	NON CONTACT WOUND WARMING WOUND COVER



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

A6261	WOUND FILLER NOT ELSEWHERE CALSSIFIED GEL PASTE PE
A6262	WOUND FILLER NOT ELESWHERE CLASSIFIED DRY FOAM PER
A6549	GRADIENT COMPRESSION STOCKING, NOT OTHERWISE SPECIFIED
A6550	WOUND CARE SET , FOR NEGATIVE PRESSURE WOUND VAC
A7025	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM VEST, REPLACEMENT
A9276	SENSOR; INVASIVE (E.G. SUBCUTANEOUS), DISPOSABLE, FOR USE WITH INTERSTITIAL
A9277	TRANSMITTER; EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM
A9278	RECEIVER (MONITOR); EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM
A9279	MONITORING FEATURE/DEVICE, STAND-ALONE OR INTEGRATED, ANY TYPE, INCLUDES ALL ACCESSORIES, COMPONENTS AND ELECTRONICS, NOT OTHERWISE CLASSIFIED
A9280	ALERT OR ALARM DEVICE, NOT OTHERWISE CLASSIFIED
A9507	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT INDIUM IN 111 CAPROMAB PENDETIDE, PER DOSE
A9542	INDIUM IN-111 IBRITUMOMAB TIUXETAN, DIAGNOSTIC, PER STUDY DOSE, UP TO 5 MILLICURIES
A9543	YTTRIUM Y-90 IBRITUMOMAB TIUXETAN, THERAPEUTIC, PER TREATMENT DOSE, UP TO 40 MILLICURIES
A9544	IODINE I-131 TOSITUMOMAB, DIAGNOSTIC, PER STUDY DOSE
A9545	IODINE I-131 TOSITUMOMAB, THERAPEUTIC, PER TREATMENT DOSE
A9580	SODIUM FLUORIDE F-18, DIAGNOSTIC, PER STUDY DOSE, UP TO 30 MILLICURIES
A9699	SUPPLY OF RADIOPHARMACEUTICAL THERAPEUTIC IMAGING NOT OTHERWISE CLASSIFIED
A9999	MISCELLANEOUS DME SUPPLY OR ACCESSORY, NOT
C1300	HYPERBARIC OXYGEN UNDER PRESSURE, FULL BODY CHAMBER,
C1721	CARDIOVERTER-DEFIBRILLATOR, DUAL CHAMBER (IMPLANTABLE)
C1722	INFUSION PUMP, PROGRAMMABLE (IMPLANTABLE)
C1767	GENERATOR, NEUROSTIMULATOR (IMPLANTABLE), NON-RECHARGEABLE
C1772	INFUSION PUMP, PROGRAMMABLE (IMPLANTABLE)
C1777	LEAD, CARDIOVERTER-DEFIBRILLATOR, ENDOCARDIAL SINGLE COIL (IMPLANTABLE)
C1778	LEAD, NEUROSTIMULATOR (IMPLANTABLE)
C1780	LENS, INTRAOCULAR (NEW TECHNOLOGY)
C1780	LENS, INTRAOCULAR (NEW TECHNOLOGY)
C1789	PROSTHESIS, BREAST (IMPLANTABLE)
C1818	INTEGRATED KERATOPROSTHESIS
C1821	INTERSPINOUS PROCESS DISTRACTION DEVICE (IMPLANTABLE)
C1882	CARDIOVERTER-DEFIBRILLATOR, OTHER THAN SINGLE OR DUAL CHAMBER (IMPLANTABLE)
C1891	INFUSION PUMP, NON-PROGRAMMABLE, PERMANENT (IMPLANTABLE)
C1895	LEAD, CARDIOVERTER-DEFIBRILLATOR, ENDOCARDIAL DUAL COIL (IMPLANTABLE)
C1896	LEAD, CARDIOVERTER-DEFIBRILLATOR, OTHER THAN ENDOCARDIAL SINGLE OR DUAL COIL (IMPLANTABLE)
C2626	INFUSION PUMP, NON-PROGRAMMABLE, TEMPORARY (IMPLANTABLE)
C8903	MAGNETIC RESONANCE IMAGING WITH CONTRAST, BREAST; UNIILATERAL



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

<b>C8904</b>	MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST, BREAST; UNILATERAL
<b>C8905</b>	MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, BREAST; UNILATERAL
<b>C8906</b>	MAGNETIC RESONANCE IMAGING WITH CONTRAST, BREAST; BILATERAL
<b>C8907</b>	MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST, BREAST; BILATERAL
<b>C8908</b>	MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, BREAST; BILATERAL
<b>C8931</b>	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, SPINAL CANAL AND CONTENTS
<b>C8932</b>	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, SPINAL CANAL AND CONTENTS
<b>C8933</b>	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY CONTRAST, SPINAL CANAL AND CONTENTS
<b>C9249</b>	INJECTION, CERTOLIZUMAB PEGOL, 1 MG
<b>C9257</b>	INJECTION, BEVACIZUMAB, 0.25 MG
<b>C9270</b>	INJECTION, IMMUNE GLOBULIN (GAMMAPLEX), INTRAVENOUS, NON-LYOPHILIZED {E.G., LIQUID}, 500 MG
<b>C9273</b>	SIPULEUCEL-T, MINIMUM OF 50 MILLION AUOTLOGOUS CD54+ CELLS ACTIVATED WITH PAP-GM-CSF, INCLUDING LEUKAPHERESIS AND ALL OTHER PREPARATORY PROCEDURES, PER INFUSION
<b>C9354</b>	ACELLULAR PERICARDIAL TISSUE MATRIX OF NON-HUMAN ORIGIN (VERITAS), PER SQUARE CM
<b>C9356</b>	TENDON, POROUS MATRIX OF CROSS-LINKED COLLAGEN & GLYCOSAMINOGLYCAN MATRIX, PER SQ CM
<b>C9358</b>	DERMAL SUBSTITUTE, NATIVE, NON-DENATURED COLLAGEN, PER 0.5 SQ CM
<b>C9360</b>	DERMAL SUBSTITUTE, NATIVE, NON-DENATURED COLLAGEN, NEONATAL BOVINE ORIGIN (SURGIMEND COLLAGEN MATRIX), PER 0.5 SQ CM
<b>C9363</b>	SKIN SUBSTITUTE, INTEGRA MESHED BILAYER WOUND MATRIX, PER SQ CM
<b>C9364</b>	PORCINE IMPLANT, PERMACOL, PER SQ CM
<b>C9367</b>	SKIN SUBSTITUTE, ENDOFORM DERMAL TEMPLATE, PER SQ CM
<b>C9716</b>	CREATIONS OF THERMAL ANAL LESIONS BY RADIOFREQUENCY ENERGY
<b>C9724</b>	ENDOSCOPIC FULL-THICKNESS PLICATION IN THE GASTRIC CARDIA USING ENDOSCOPIC PLICATION SYSTEM (EPS); INCLUDES ENDOSCOPY
<b>C9727</b>	INSERTION OF IMPLANTS INTO THE SOFT PALATE; MINIMUM OF THREE IMPLANTS
<b>C9800</b>	DERMAL INJECTION PROCEDURE(S) FOR FACIAL LIPODYSTROPHY SYNDROME (LDS) AND PROVISION OF RADIESSE OR SCULPTRA DERMAL FILLER, INCLUDING ALL ITEMS AND SUPPLIES
<b>D7940</b>	OSTEOPLASTY FOR ORTHOGNATHIC DEFORMITIES
<b>D7941</b>	OSTEOTOMY - MANDIBULAR RAMI
<b>D7943</b>	OSTEOTOMY - MANDIBULAR RAMI WITH BONE GRAFT; INCL OBTAINING THE GRAFT
<b>D7944</b>	OSTEOTOMY, MANDIBULAR RAMI W/GRAFT
<b>D7945</b>	OSTEOTOMY, BODY OF MANDIBLE
<b>D7946</b>	LE FORT I MAXILLA TOTAL
<b>D7947</b>	LE FORT I MAXILLA SEGMENTED
<b>D7948</b>	LE FORT II OR III W/O BONE GRAFT



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

D7949	LE FORT II OR III W/ BONE GRAFT
D7950	OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR MAXILLA
D7995	SYNTHETIC GRAFT, MADIBLE OR FACIAL BONES
D7996	IMPLANT-MANDIBLE FOR AUGMENTATION PURPOSES, BY REPORT
E0193	POWERED AIR FLOTATION BED (LOW AIR LOSS TH
E0217	WATER CIRCULATING HEAT PAD WITH PUMP
E0218	WATER CIRCULATING COLD PAD WITH PUMP
E0221	INFRARED HEATING PAD SYSTEM
E0231	NON CONTACT WOUND WARMING DEVICE
E0232	WARMING CARD FOR USE WITH DEVICE
E0236	PUMP FOR WATER CIRCULATING PAD
E0350	CONTROL UNIT FOR ELECTRONIC BOWEL IRRIGATION/EVACUATION
E0481	INTRAPULMONARY RERCUSSIVE VENTILATION SYSTEM AND RELATED ACCESSORIES
E0483	HIGH FREQUENCY CHEST WALL OSCILLATION AIR PULSE GENERATOR SYSTEM
E0485	ORAL DEVICE TO REDUCE UPPER AIRWAY COLLAPSIBILITY-PREFABRICATED
E0486	ORAL DEVICE TO REDUCE UPPER AIRWAY COLLAPSIBILITY-CUSTOM
E0616	IMPLANTABLE CARDIAC EVENT RECORDER WITH MEMORY
E0617	EXTERNAL DEFIBRILLATOR
E0620	SKIN PIERCING DEVICE FOR COLLECTION OF CAPILLARY BLOOD, LASER, EACH
E0637	COMBINATION SIT TO STAND SYSTEM, ANY SIZE INCLUDING PEDIATRIC, WITH SEATLIFT FEATURE, WITH OR WITHOUT WHEELS
E0638	STANDING FRAME SYSTEM, ONE POSITION (E.G. UPRIGHT, SUPINE O PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC
E0641	STANDING FRAME SYSTEM, MULTI-POSITION (E.G. THREE-WAY STANDER), ANY SIZE
E0642	STANDING FRAME SYSTEM, MOBILE (DYNAMIC STANDER), ANY SIZE INCLUDING PEDIATRIC
E0691	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQUARE FEET
E0692	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS TIMER AND EYE PROTECTION 4 FOOT PANEL
E0693	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS TIMER AND EYE PROTECTION 6 FOOT PANEL
E0694	ULTRAVIOLET MULTIDIRECTIONAL LIGHT THERAPY SYSTEM IN 6 FOOT CABINET, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION
E0740	INCONTINENCE TREATMENT SYSTEM, PELVIC FLOOR STIMULATOR, MONIOR SENSOR AND/OR TRAINER
E0745	NEUROMUSCULAR STIMULATOR, ELECTRONIC SHOCK UNIT
E0746	ELECTROMYOGRAPHY (EMG), BIOFEEDBACK DEVICE
E0747	OSTEOGENESIS STIMULATOR (NON-INVASIVE)
E0748	OSTEOGENESIS STIMULATOR, ELECTRICAL NONINV
E0749	OSTEOGENESIS STIMULATOR, ELECTRICAL, SURGICALLY IMPLANTED
E0760	OSTOGENESIS STIMULATOR LOW INTENSITY ULTRA
E0761	NON THERMAL PULSED HIGH FREQUENCY RADIOWAVES, ELECTROMAGNETIC ENERGY TREATMENT DEVICE



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

E0762	TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION DEVICE SYSTEM
E0764	NEUROMUSCULAR STIMULATOR
E0769	ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE, NOT OTHERWISE CLASSIFIED
E0770	FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR MUSCLE GROUPS, ANY TYPE, COMPLETE SYSTEM, NOT OTHERWISE SPECIFIED
E0782	INFUSION PUMP, IMPLANTABLE, NON PROGRAMMABLE
E0783	INFUSION PUMP, IMPLANTABLE, PROGRAMMABLE
E0784	EXTERNAL AMBULATORY INFUSION PUMP, INSULIN
E0935	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE ON KNEE ONLY
E0936	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE OTHER THAN
E1399	DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS
E1800	DYNAMIC ADJUSTABLE ELBOW EXTENSION/FLEXION DEVICE
E1801	BI-DIRECTIONAL STRETCH ELBOW DEVICE
E1802	DYNAMIC ADJUSTABLE FOREARM DEVICE
E1805	DYNAMIC ADJUSTABLE WRIST DEVICE
E1806	BI-DIRECTIONAL STRETCH WRIST DEVICE
E1810	DYNAMIC ADJUSTABLE KNEE DEVICE
E1811	BI-DIRECTIONAL STATIC PROGRESSIVE STRETCH KNEE DEVICE WITH RANGE OF MOTION ADJUSTMENT, INCLUDES CUFF
E1812	DYNAMIC KNEE DEVICE W/RESISTANCE CONTROL
E1815	DYNAMIC ADJUSTABLE ANKLE DEVICE
E1816	BI-DIRECTIONAL STRETCH ANKLE DEVICE
E1818	BI-DIRECTIONAL STRETCH FOREARM DEVICE
E1821	REPLACEMENT MATERIAL
E1825	DYNAMIC ADJUSTABLE FINGER DEVICE
E1830	DYNAMIC ADJUSTABLE TOE DEVICE
E1831	STATIC PROGRESSIVE STRETCH TOE DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES
E1840	DYNAMIC ADJUSTABLE SHOULDER DEVICE
E1841	MULTI-DIRECTIONAL STRETCH SHOULDER DEVICE
E2120	PULSE GENERATOR SYSTEM FOR TYMPANIC TX
E2230	MANUAL WHEELCHAIR ACCESSORY, MANUAL STANDING SYSTEM
E2301	POWER WHEELCHAIR ACCESSORY, POWER STANDING SYSTEM
E2399	POWER WHEELCHAIR ACCESSORY, NOT OTHERWISE CLASSIFIED
E2402	NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL
E2599	ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED
G0130	SINGLE ENERGY X-RAY ABSORPTIOMETRY (SEX A) BONE DENSITY STUDY, ONE OR MORE SITES; APPENDICULAR SKELETON
G0173	LINEAR ACCELERATOR BASED STEREOTACTIC RADIOSURGERY, ONE SESSION
G0176	ACTIVITY THERAPY FOR DISABLING MENTAL HEALTH PROBLEMS
G0219	PET IMAGING, WHOLE BODY
G0235	PET IMAGING, ANY SITE, NOT OTHERWISE SPECIFIED



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

<b>G0251</b>	LINEAR ACCELERATOR BASED STEREOTACTIC RADIOSURGERY, 5 SESSIONS
<b>G0252</b>	PET IMAGING FOR INITIAL DIAGNOSIS OF BREAST CANCER AND STAGING
<b>G0255</b>	CURRENT PERCEPTION THRESHOLD/SENSORY NERVE CONDUCTION TEST, PER LIMB, ANY NERVE
<b>G0282</b>	ELECTRICAL STIMULATION, (UNATTENDED), TO ONE OR MORE AREAS, FOR WOUND CARE
<b>G0283</b>	ELECTRICAL STIMULATION (UNATTENDED), TO ONE OR MORE AREAS FOR INDICATIONS
<b>G0295</b>	ELECTROMAGNETIC THERAPY FOR WOUND CARE
<b>G0302</b>	PRE-OP PULMONARY SURGERY SERVICES FOR LVRS, 16 DAYS
<b>G0303</b>	PRE-OP PULMONARY SURGERY SERVICES FOR LVRS, 10-15 DAYS
<b>G0304</b>	PRE-OP PULMONARY SURGERY SERVICES FOR LVRS, 1-9 DAYS
<b>G0305</b>	POST-OP SERVICES AFTER LVRS, 6 DAYS
<b>G0339</b>	IMAGE GUIDED ROBOTIC STEREOTACTIC RADIOSURGERY, ONE SESSION
<b>G0340</b>	IMAGE GUIDED ROBOTIC STEREOTACTIC RADIOSURGERY, 2-5 SESSIONS
<b>G0341</b>	PERCUTANEOUS ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION
<b>G0342</b>	LAPAROSCOPY FOR ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION
<b>G0343</b>	LAPAROTOMY FOR ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION
<b>G0398</b>	HOME SLEEP STUDY TEST (HST) W/ TYPE II PORTABLE MONITOR, UNATTENDED, MINIMUM OF 7 CHANNELS: EEG, EOG, EMG, ECG/HEART RATE
<b>G0399</b>	HOME SLEEP TEST (HST) WITH TYPE III PORTABLE MONITOR, UNATTENDED; MINIMUM OF 4 CHANNELS: 2 RESPIRATORY MOVEMENT/AIRFLOW
<b>G0400</b>	HOME SLEEP TEST (HST) WITH TYPE IV PORTABLE MONITOR, UNATTENDED; MINIMUM OF 3 CHANNELS
<b>G0416</b>	SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION FOR PROSTATE NEEDLE SATURATION BIOPSY SAMPLING, 1-20 SPECIMENS
<b>G0417</b>	SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION FOR PROSTATE NEEDLE SATURATION BIOPSY SAMPLING, 21-40 SPECIMENS
<b>G0418</b>	SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION FOR PROSTATE NEEDLE SATURATION BIOPSY SAMPLING, 41-60 SPECIMENS
<b>G0419</b>	SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION FOR PROSTATE NEEDLE SATURATION BIOPSY SAMPLING, GREATER THAN 60 SPECIMENS
<b>G0428</b>	COLLAGEN MENISCUS IMPLANT PROCEDURE FOR FILLING MENISCAL DEFECTS (E.G., CMI, COLLAGEN SCAFFOLD, MENAFLEX)
<b>G0429</b>	DERMAL FILLER INJECTION(S) FOR THE TREATMENT OF FACIAL LIPODYSTROPHY SYNDROME (LDS) (E.G., AS A RESULT OF HIGHLY ACTIVE ANTIRETROVIRAL THERAPY)
<b>G0440</b>	APPLICATION OF TISSUE CULTURED ALLOGENEIC SKIN SUBSTITUTE OR DERMAL SUBSTITUTE; FOR USE ON LOWER LIMB, INCLUDES THE SITE
<b>G0441</b>	APPLICATION OF TISSUE CULTURED ALLOGENEIC SKIN SUBSTITUTE OR DERMAL SUBSTITUTE; FOR USE ON LOWER LIMB, INCLUDES THE SITE
<b>G3001</b>	ADMINISTRATION AND SUPPLY OF TOSITUMOMAB, 450 MG
<b>G9143</b>	WARFARIN RESPONSIVENESS TESTING BY GENETIC TECHNIQUE USING ANY METHOD, ANY



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

	NUMBER OF SPECIMEN(S)
<b>G9147</b>	OUTPATIENT INTRAVENOUS INSULIN TREATMENT (OIVIT) EITHER PULSATILE OR CONTINUOUS, BY ANY MEANS, GUIDED BY THE RESULTS OF MEASUREMENTS FOR: RESPIRATORY QUOTIENT; AND/OR, URINE UREA NITROGEN (UUN); AND/OR, ARTERIAL, VENOUS OR CAPILLARY GLUCOSE; AND/OR POTASSIUM CONCENTRATION
<b>J0129</b>	INJECTION, ABATACEPT, 10 MG
<b>J0135</b>	INJECTION, ADALIMUMAB, 20 MG
<b>J0470</b>	DIMERCAPROL INJECTION
<b>J0585</b>	BOTULINUM TOXIN TYPE A, PER UNIT
<b>J0586</b>	INJECTION, ABOBOTULINUMTOXINA, 5 UNITS
<b>J0587</b>	BOTULINUM TOXIN TYPE B, PER 100 UNITS
<b>J0600</b>	EDETATE CALCIUM DISODIUM INJECTION
<b>J0696</b>	INJECTION, CEFTRIAZONE SODIUM, PER 250 MG
<b>J0698</b>	CEFOTAXIME SODIUM, PER GM
<b>J0718</b>	INJECTION, CERTOLIZUMAB PEGOL, 1 MG
<b>J0725</b>	INJECTION, CHORIONIC GONADOTROPIN PER 1,0
<b>J0725</b>	INJECTION, CHORIONIC GONADOTROPIN PER 1,000 USP
<b>J0800</b>	INJECTION, CORTICOTROPIN, UP TO 40 UNITS
<b>J0895</b>	DESFERAL INJECTION
<b>J1325</b>	INJECTION EPOPROSTENOL 0.5MG
<b>J1438</b>	INJECTION, ETANERCEPT, 25 MG
<b>J1440</b>	INJECTION, FILGRASTIM (G-CSF), 300 MCG
<b>J1441</b>	INJECTION, FILGRASTIM (G-CSF); 480 MCG
<b>J1459</b>	INJECTION, IMMUNE GLOBULIN (PRIVIGEN), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG
<b>J1460</b>	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 1 CC
<b>J1559</b>	INJECTION, IMMUNE GLOBULIN (HIZENTRA), 100 MG
<b>J1560</b>	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, OVER 10 CC
<b>J1561</b>	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, 500 MG
<b>J1562</b>	INJECTION, IMMUNE GLOBULIN (VIVAGLOBIN), 100 MG
<b>J1566</b>	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G. POWDER), 500 MG
<b>J1568</b>	INJECTION, IMMUNE GLOBULIN, (OCTAGAM), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG
<b>J1569</b>	INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG
<b>J1572</b>	INJECTION, IMMUNE GLOBULIN, (FLEBOGAMMA), IV, NON-LYOPHILIZED (E.G. LIQUID), 500 MG
<b>J1599</b>	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), NOT OTHERWISE SPECIFIED, 500 MG
<b>J1675</b>	INJECTION, HISTRELIN ACETATE, 10 MICROGRAMS
<b>J1745</b>	INJECTION, INFLIXIMAB, 10MG
<b>J1815</b>	INJECTION, INSULIN, PER 5 UNITS
<b>J1817</b>	INSULIN FOR ADMINISTRATION THROUGH DME (I.E., INSULIN PUMP) PER 50 UNITS
<b>J1950</b>	INJECTION, LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), PER



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

	3.75 MG
J2278	INJECTION, ZICONOTIDE, 1 MICROGRAM
J2357	INJECTION, OMALIZUMAB, 5 MG
J2503	INJECTION, PEGAPTANIB SODIUM, 0.3 MG
J2510	INJECTION, PENICILLIN G PROCAINE
J2778	INJECTION,RANIBIZUMAB,0.1 MG
J2850	SECRETIN INJECTION
J2940	INJECTION, SOMATREM, 1MG
J2941	INJECTION, SOMATROPIN, 1MG
J3262	INJECTION, TOCILIZUMAB, 1 MG
J3285	INJECTION, TREPROSTINIL, 1 MG
J3315	INJECTION, LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), PER 3.75 MG
J3355	INJECTION, UROFOLLITROPIN, 75 IU
J3357	INJECTION, USTEKINUMAB, 1 MG
J3490	UNCLASSIFIED DRUGS
J3520	EDETATE DISODIUM
J3590	UNCLASSIFIED BIOLOGICS
J7199	HEMOPHILIA CLOTTING FACTOR, NOT OTHERWISE CLASSIFI
J7311	FLUOCINOLONE ACETONIDE, INTRAVITREAL IMPLANT
J7321	HYALURONAN OR DERIVATIVE, HYALGAN OR SUPARTZ, FOR INTRA-ARTICULAR INJECTION
J7323	HYALURONAN OR DERIVATIVE, EUFLEXXA, FOR INTRAARTICULAR INJ, PER DOSE
J7324	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INECTION, PER DOSE
J7325	HYALURON OR DERIVATIVE, SYNVISC OR SYNVISC-ONE, FOR INTRA-ARTICULARE INJECTION, 1 MG
J7330	AUTOLOGOUS CULTURED CHONDROCYTES, IMPLANT
J7599	IMMUNOSUPPRESSIVE DRUG NOT OTHERWISE CLASS
J7685	TOBRAMYCIN, INHALATION SOLUTION
J7686	TREPROSTINIL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED,
J7699	NOC DRUGS, INHALATION SOLUTION ADMINSTERED THROUGH
J7799	NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTER
J8597	ANTIEMETIC DRUG, ORAL, NOT OTHERWISE SPECIFIED
J9035	INJECTION, BEVACIZUMAB, 10 MG
J9055	INJECTION, CETUXIMAB, 10 MG
J9155	INJECTION, DEGARELIX, 1 MG
J9202	GOSERELIN ACETATE IMPLANT PER 3.6 MG
J9217	LEUPROLIDE ACETATE, FOR DEPOT SUSPENSION, 7.5 MG
J9218	LEUPROLIDE ACETATE, PER 1 MG
J9225	HISTERLIN IMPLANT (VANTAS), 50 MG
J9226	HISTRELIN IMPLANT (SUPPRELIN LA), 50MG
J9303	INJECTION, PANITUMUMAB, 10 MG
J9310	INJECTION, RITUXIMAB, 100 MG



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

J9310	INJECTION, RITUXIMAB, 100 MG
J9355	TRASTUZUMAB, 10MG
J9999	NOT OTHERWISE CLASSIFIED, ANTINEOPLASTIC D
K0455	INFUSION PUMP USED FOR UNINTERRUPTED ADMINISTRATION OF EPOPRESTENOL
K0606	AUTOMATIC EXTERNAL DEFIBRILLATOR, WITH INTEGRATED ELECTRONC CARDIOGRAM ANALYSIS, GARMENT TYPE
L0112	CRANIAL CERVICAL ORTHOSIS, CONGENITAL TORTICOLLIS TYPE, WITHOR WITHOUT SOFT INTERFACE MATERIAL, ADJUSTABLE RANGE OF MOTION
L0113	CRANIAL CERVICAL ORTHOSIS, TORTICOLLIS TYPE, WITH OR WITHOUT SORFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L0999	ADDITION TO SPINAL ORTHOSIS, NOT OTHERWISE SPECIFIED
L1499	SPINAL ORTHOTIC, NOT OTHERWISE SPECIFIED
L2999	UNLISTED PROCEDURES FOR LOWER EXTREMITY ORTHOSES
L3999	UNLISTED PROCEDURES FOR UPPER LIMB ORTHOSIS
L5856	ADDITION TO LOWER EXTREMITY PROSTHESIS
L5857	ADDITION TO LOWER EXTREMITY PROSTHESIS
L5858	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, STANCE PHASE ONLY
L5973	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL, INCLUDES POWER SOURCE
L5999	UNLISTED PROCEDURES FOR LOWER EXTREMITY PR
L8039	BREAST PROSTHESIS; NOT OTHERWISE SPECIFIED
L8499	UNLISTED PROCEDURE FOR MISCELLANEOUS PROSTHETIC SE
L8600	IMPLANTABLE BREAST PROSTHESIS, SILICOME OR EQUAL
L8603	INJECTABLE BULKING AGENT, COLLAGEN, URINARY TRACT
L8606	INJECTABLE BULKING AGENT, SYNTHETIC, URINARY TRACT
L8609	ARTIFICIAL CORNEA
L8614	COCHLEAR DEVICE
L8619	COCHLEAR IMPLANT EXTERNAL SPEECH PROCESSOR
L8627	COCHLEAR IMPLANT, EXTERNAL SPEECH PROCESSOR, COMPONENT, REPLACEMENT
L8628	COCHLEAR IMPLANT, EXTERNAL SPEECH PROCESSOR, COMPONENT, REPLACEMENT
L8680	IMPLANTABLE NEUROSTIMULATOR ELECTRODE, EACH
L8682	RADIOFREQUENCY TRANSMITTER (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR RADIOFREQUENCY RECEIVER
L8683	RADIOFREQUENCY TRANSMITTER (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR RADIOFREQUENCY RECEIVER
L8685	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, SINGLE ARRAY
L8686	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, SINGLE ARRAY, NON-RECHARGEABLE, INCLUDES EXTENSION
L8687	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, DUAL ARRAY, RECHARGEABLE, INCLUDES EXTENSION
L8688	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, DUAL ARRAY, NON-RECHARGEABLE, INCLUDES EXTENSION



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

L8690	AUDITORY OSSEOINTEGRATED DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS
L8691	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, REPLACEMENT
L8692	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, USED WITHOUT OSSEOINTEGRATION, BODY WORN, INCLUDES HEADBAND OR OTHER MEANS OF EXTERNAL ATTACHMENT
L8693	AUDITORY OSSEOINTEGRATED DEVICE ABUTMENT, ANY LENGTH, REPLACEMENT ONLY
L8699	PROSTHETIC IMPLANT NOT OTHERWISE SPECIFIED
L9900	ORTHOTIC AND PROSTHETIC SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS "L" CODE
M0075	CELLULAR THERAPY
M0076	PROLOTHERAPY
M0300	IV CHELATION THERAPY
P2031	HAIR ANALYSIS (EXCLUDING ARSENIC)
Q0515	INJECTION, SERMORELIN ACETATE, 1 MICROGRAM
Q1003	NEW TECHNOLOGY INTRAOCULAR LENS CATEGORY 3 (REDUCED SPHERICAL ABERRATION)
Q1004	NEW TECHNOLOGY INTRAOCULAR LENSE CATEGORY 4 AS DEFINED IN FEDERAL REGISTER NOTICE
Q1005	NEW TECHNOLOGY INTRAOCULAR LENSE CATEGORY 5 AS DEFINED IN FEDERAL REGISTER NOTICE
Q2026	INJECTION, RADIESSE, 0.1 ML
Q2027	INJECTION, SCULPTRA, 0.1 ML
Q3001	RADIOELEMENTS FOR BRACHYTHERAPY, ANY TYPE, EACH
Q4074	ILOPROST, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM
Q4080	ILOPROST, INHAL SOL, FDA-APPROVED FINAL PROD, NON-COMPOUNDED, ADMIN'D THRU DME, UNIT DOSE FORM, 20 MCG
Q4100	SKIN SUBSTITUTE, NOT OTHERWISE SPECIFIED
Q4101	SKIN SUBSTITUTE, APLIGRAF, PER SQUARE CENTIMETER
Q4102	SKIN SUBSTITUTE, OASIS WOUND MATRIX, PER SQUARE CENTIMETER
Q4103	SKIN SUBSTITUTE, OASIS BURN MATRIX, PER SQUARE CENTIMETER
Q4104	SKIN SUBSTITUTE, INTEGRA BILAYER MATRIX WOUND DRESSING (BMWWD), PER SQUARE CENTIMETER
Q4105	SKIN SUBSTITUTE, INTEGRA DERMAL REGENERATION TEMPLATE (DRT), PER SQUARE CENTIMETER
Q4106	SKIN SUBSTITUTE, DERMAGRAFT, PER SQUARE CENTIMETER
Q4107	SKIN SUBSTITUTE, GRAFTJACKET, PER SQUARE CENTIMETER
Q4108	SKIN SUBSTITUTE, INTEGRA MATRIX, PER SQUARE CENTIMETER
Q4110	SKIN SUBSTITUTE, PRIMATRIX, PER SQUARE CENTIMETER
Q4111	SKIN SUBSTITUTE, GAMMAGRAFT, PER SQUARE CENTIMETER
Q4112	ALLOGRAFT, CYMETRA, INJECTABLE, 1CC
Q4113	ALLOGRAFT, GRAFTJACKET EXPRESS, INJECTABLE, 1CC
Q4114	INTEGRA FLOWABLE WOUND MATRIX, INJECTABLE, ICC



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

Q4116	SKIN SUBSTITUTE, ALLODERM, PER SQ CM
Q4117	HYALOMATRIX, PER SQUARE CENTIMETER
Q4118	MATRISTEM MICROMATRIX, 1 MG
Q4119	MATRISTEM WOUND MATRIX, PER SQUARE CENTIMETER
Q4120	MATRISTEM BURN MATRIX, PER SQUARE CENTIMETER
REV 0404	POSITRON EMISSION TOMOGRAPHY
REV 0413	HYPERBARIC OXYGEN THERAPY
REV 2105	ALTERNATIVE THERAPY SERVICES - BIOFEEDBACK
S0122	INJ MENOTROPINS 75IU
S0126	INJ FOLLITROPIN, ALFA 75IU
S0128	INJ FOLLITROPIN, BETA 75IU
S0148	INJECTION, PEGYLATED INTERFERON ALFA-2B, 10 MCS
S0155	STERILE DILUTANT FOR EPOPROSTENOL 50 ML
S0157	BECAPLERMIN GEL 0.01% 0.5 GM
S0189	TESTOSTERONE PELLET, 75MG
S0800	LASER IN SITU KERATOMILEUSIS (LASIK)
S0810	PHOTOREFRACTIVE KERATECTOMY
S1025	INHALED NITRIC OXIDE FOR TREATMENT OF HYPOXIC RESPIRATORY FAILURE IN THE NEONATE; PER DIEM
S1030	CONTINUOUS NONINVASIVE GLUCOSE MONITORING DEVICE, PURCHASE
S1031	CONTINUOUS NONINVASIVE GLUCOSE MONITORING DEVICE, RENTAL
S1040	CRANIAL REMOLDING ORTHOSIS, PEDIATRIC, RIGID, WITH SOFT INTERFACE MATERIAL, CUSTOM FABRICATED, INCLUDES FITTING AND ADJU
S2066	BREAST RECONSTR W/GLUTEAL ARTERY PERFORATOR (GAP) FLAP
S2067	BREAST RECONSTR OF SINGLE BREAST W/"STACKED" DIEP FLAP(S)
S2068	BREAST RECONSTR W/DIEP FLAP OR SIEA FLAP, INCL MICROVASC TRANSFER & CLOSE OF DONOR SITE & SHAPING INTO BREAST, UNILAT
S2080	LASER-ASSISTED UVULOPLATOPLASTY (LAUP)
S2083	ADJUSTMENT OF GASTRIC BAND DIAMETER VIA SUBCUTANEOUS PORT
S2083	ADJUSTMENT OF GASTRIC BAND DIAMETER VIA SUBCUTANEOUS PORT BY INJECTION OR ASPIRATION OF SALINE
S2095	TRANSCATHETER OCCLUSION OR EMBOLIZATION FOR TUMOR DESTRUCTION USING YTTRIUM-90 MICROSPHERES
S2102	ISLET CELL TISSUE TRANSPLANT FROM PANCREAS; ALLOGENEIC
S2107	ADOPTIVE IMMUNOTHERAPY
S2112	ARTHROSCOPY, KNEE, FOR HARVESTING CARTILAGE
S2117	ARTHROEREISIS, SUBTALAR
S2118	METAL-ON-METAL TOTAL HIP RESURFACING, INCL ACETABULAR AND FEMORAL COMPONENTS
S2202	ECHOSCLEROTHERAPY
S2230	IMPLANTATION OF MAGNETIC COMPONENT OF HEARING DEVICE ON OSSICLES IN MIDDLE EAR
S2235	IMPLANTATION OF AUDITORY BRAIN STEM IMPLANT
S2270	INSERTION OF VAGINAL CYLINDER FOR APPLICATION OF RADIATION SOURCE FOR CLINICAL



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

	BRACHYTHERAPY
S2300	ARTHROSCOPY, SHOULDER W/THERMAL INDUCED CAPSULORRHAPHY
S2340	CHEMODENERVATION OF ABDUCTOR MUSCLE, VOCAL CORD
S2341	CHEMODENERVATION OF ADDUCTOR MUSCLE, VOCAL CORD
S2344	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH ENLARGEMENT OF SINUS OSTIUM OPENING USING INFLATABLE DEVICE (I.E., BALLOON SINUPLA
S2348	DECOMPRESSION OF INTERVERTEBRAL DISC
S2360	PERCUTANEOUS VERTEBROPLASTY, ONE VEREBRAL BODY, UNILATERAL OR BILATERAL INJECTION; CERVICAL
S2361	EACH ADDITIONAL CERVICAL VEREBRAL BODY, VEREBRAL BODY
S2400	REPAIR, CONGENITAL HERNIA IN THE FETUS, USING TEMPORARY TRACHEAL OCCLUSION, PROCEDURE PERFORMED IN UTERO
S2401	REPAIR, URINARY TRACT OBSTRUCTION IN THE FETUS, PROCEDURE PERFORMED IN UTERO
S2402	REPAIR, CONGENITAL CYSTIC ADENOMATOID MALFORMATION IN THE FETUS, PROCEDURE PERFORMED IN UTERO
S2403	REPAIR, EXTRALOBAR PULMONARY SEQUESTRATION IN THE FETUS, PROCEDURE PERFORMED IN UTERO
S2404	REPAIR, MYELOMENINGOCELE IN THE FETUS, PROCEDURE PERFORMED IN UTERO
S2405	REPAIR OF SACROCOCCYGEAL TERATOMA IN THE FETUS, PROCEDURE PERFORMED IN UTERO
S2409	REPAIR, CONGENITAL MALFORMATION OF FETUS, PROCEDURE PERFORMED IN UTERO, NOT OTHERWISE CLASSIFIED
S3711	CIRCULATING TUMOR CELL TEST
S3713	KRAS MUTATION ANALYSIS TESTING
S3800	GENETIC TESTING FOR AMYOTROPHIC LATERAL SCLEROSIS (ALS)
S3818	COMPLETE GENE SEQUENCE ANALYSIS; BRCA 1 GENE
S3819	COMPLETE GENE SEQUENCE ANALYSIS; BRCA 2 GENE
S3820	COMPLETE BRCA1 AND BRCA2 GENE SEQUENCE ANALYSIS FOR SUSCEPTIBILITY TO BREAST AND OVARIAN CANCER
S3822	THREE-MUTATION BRCA1 ANC BRCA2 ANALYSIS FOR SUSCEPTIBILITY TO BREAST AND OVARIAN CANCER IN ASHKENAZI INDIVIDUALS
S3823	THREE-MUTATION BRCA1 ANC BRCA2 ANALYSIS FOR SUSCEPTIBILITY TO BREAST AND OVARIAN CANCER IN ASHKENAZI INDIVIDUALS
S3828	COMPLETE GENE SEQUENCE ANALYSIS; MLH1 GENE
S3829	COMPLETE GENE SEQUENCE ANALYSIS; MLH2 GENE
S3830	COMPLETE MLH1 AND MLH2 GENE SEQUENCE ANALYSIS FOR HEREDITARY NONPOLYPOSIS COLORECTAL CANCER (HNPCC) GENETIC TESTING
S3831	SINGLE-MUTATION ANAYLSIS (IN INDIVIDUAL W/ KNOWN MLH1 AND MLH2 MUTATION IN FAMILY) FOR HEREDITARY NONPOLYPOSIS COLORECT
S3833	COMPLETE APC GENE SEQUENCE ANALYSIS FOR SUSCEPTIBILITY TO FAMILIAL ADENOMATOUS PLYPOSIS (FAP) AND ATTENUATED FAP
S3834	SINGLE-MUTATION ANALYSIS FOR SUSCEPTIBILITY TO FAMILIAL ADENOMATOUS PLYPOSIS (FAP) AND ATTENUATED FAP
S3840	DNA ANALYSIS FOR GERMLINE MUTATIONS OF THE RET PROTO-ONCOGEN FOR



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

	SUSCEPTIBILITY TO MULTIPLE ENDOCRINE NEOPLASIA TYPE 2
S3852	NNA ANALYSIS FOR APOE EPSILON 4 ALLEL FOR SUSCEPTIBILITY TO ALZHEIMER'S DISEASE
S3854	GENE EXPRESSION PROFILING PANEL FOR USE IN THE MANAGEMENT OF BREAST CANCER TREATMENT
S3855	GENETIC TESTING FOR DETECTION OF MUTATIONS IN THE PRESENILIN
S3860	GENETIC TESTING, COMPREHENSIVE CARDIAC ION CHANNEL ANALYSIS, FOR VARIANTS IN 5 MAJOR CARDIAC ION CHANNEL GENES FOR INDIV
S3861	GENETIC TESTING, SODIUM CHANNEL, VOLTAGE-GATED, TYPE V, ALPHA SUBUNIT (SCN5A) AND VARIANTS FOR SUSPECTED BRUGADA SYNDROME
S3862	GENETIC TESTING, FAMILY-SPECIFIC ION CHANNEL ANALYSIS, FOR BLOOD-RELAT OF INDIV WHO PREV TESTED + FOR GENE VARIANT
S3865	COMPREHENSIVE GENE SEQUENCE ANALYSIS FOR HYPERTROPHIC CARDIOMYOPATHY
S3866	GENETIC ANALYSIS FOR A SPECIFIC GENE MUTATION FOR HYPERTROPHIC CARDIOMYOPATHY (HCM) IN AN INDIVIDUAL WITH KNOWN HCM MUTATION
S3870	COMPARATIVE GENOMIC HYBRIZATION MICROARRAY TESTING FOR DEVELOPMENTAL DELAY, AUTISM SPECTRUM DISORDER
S3890	DNA ANALYSIS, FECAL FOR COLORECTAL SCREENING
S3905	NON-INVASIVE ELECTRODIAGNOSTIC TESTING W/AUTO COMPUTERIZED HAND-HELD DEVICE TO STIMULATE & MEASURE NEUROMUSCULAR SIGNALS
S4042	MANAGEMENT OF OVULATION INDUCTION, PER CYCLE
S8030	SCLERAL APPLICATION OF TANTALUM RING(S) FOR LOCALIZATION OF LESIONS FOR PROTON BEAM THERAPY
S8035	MAGNETIC SOURCE IMAGING
S8040	TOPOGRAPHIC BRAIN MAPPING
S8042	MAGNETIC RESONANCE IMAGING (MRI), LOW-FIELD
S8049	INTRAOPERATIVE RADIATION THERAPY (1 ADMIN).
S8080	SCINTIMAMMOGRAPHY (RADIOIMMUNOSCINTIGRAPHY OF THE BREAST), UNILATERAL, INCLUDING SUPPLY OF RADIOPHARMACEUTICAL.
S8085	FLUORINE-18 FLUORODEOXYGLUCOSE (F-18 FDG) IMAGING USING DUAL-HEAD COINCIDENCE DETECTION SYSTEM (NON-DEDICATED PET SCAN)
S8092	ELECTRON BEAM COMPUTED TOMOGRAPHY-ULTRAFAST CT
S8940	EQUESTRIAN/HIPPOTHERAPY
S9024	PARANASAL SINUS ULTRASOUND
S9055	PROCUREN OR OTHER GROWTH FACTOR PREPARATION TO PROMOTE WOUND
S9090	VERTEBRAL AXIAL DECOMPRESSION
S9152	SPEECH THERAPY, RE-EVALUATION
S9338	HOME INFUSION THERAPY, IMMUNOTHERAPY, PER DIEM
S9355	HOME INFUSION THERAPY, CHELATION THERAPY, PER DIEM
S9359	HOME INFUSION THERAPY, ANTI-TUMOR NECROSIS FACTOR IV THERAPY; ADMIN SVCS, CARE COORD, PHARM, SUP/EQP; PER DIEM
S9435	MEDICAL FOODS FOR INBORN ERRORS OF METABOLISM
S9482	FAMILY STABILIZATION SERVICES, PER 15 MINU
S9494	HOME INFSN THRPY, ANTIBIOTIC, ANTIVIRAL, OR ANTIFUNGAL THRPY(NOT FOR USE W/ HRLY



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.

	DOSING SCHED S9497-S9504); PER DIEM
<b>S9497</b>	HOME INFSN THRPY, ANTIBIOTIC, ANTIVIRAL, OR ANTIFUNGAL THRPYONCE EVERY 3 HRS; ADMIN, CARE, PHARM, SUP/EQP; PER DIEM
<b>S9500</b>	HOME INFSN THRPY, ANTIBIOTIC, ANTIVIRAL, OR ANTIFUNGAL THRPYONCE EVERY 24 HRS; ADMIN, CARE, SUP/EQP, PHARM; PER DIEM
<b>S9501</b>	HOME INFSN THRPY, ANTIBIOTIC, ANTIVIRAL, OR ANTIFUNGAL THRPYONCE EVERY 12 HOURS; ADMIN, CARE, PHARM, SUP/EQP; PER DIEM
<b>S9502</b>	HOME INFSN THRPY, ANTIBIOTIC, ANTIVIRAL, OR ANTIFUNGAL THRPYONCE EVERY 8 HOURS; ADMIN, CARE, PHARM, SUP/EQP; PER DIEM
<b>S9503</b>	HOME INFSN THRPY, ANTIBIOTIC, ANTIVIRAL, OR ANTIFUNGAL; ONCEEVERY 6 HOURS; ADMIN, CARE, PHARM, SUP/EQP; PER DIEM
<b>S9504</b>	HOME INFUSION THERAPY, ANTIBIOTIC, ANTIVIRAL, OR ANTIFUNGAL;ONCE EVERY 4 HOURS; ADMIN, PHARM, CARE, SUP/EQP; PER DIEM
<b>S9558</b>	HOME INJECTABLE THERAPY, GROWTH HORMONE, PER DIEM
<b>S9560</b>	HOME INJECTABLE THERAPY; HORMONAL THERAPY (E.G.; LEUPROLIDE, GOSERELIN), ADMIN, PHARM, SUP/EQP, CARE; PER DIEM
<b>S9562</b>	HOME INJECTABLE THERAPY INCLUDING ADMINISTRATION SERVICES, PROFESSIONAL SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE
<b>Unlisted CPT Codes</b>	**Any unlisted code not indicated
<b>V2630</b>	ANTERIOR CHAMBER INTRAOCULAR LENS
<b>V2631</b>	IRIS SUPPORTED INTRAOCULAR LENS
<b>V2632</b>	POSTERIOR CHAMBER INTRAOCULAR LENS
<b>V2787</b>	ASTIGMATISM CORRECTING FUNCTION OF INTRAOCULAR LENS
<b>V2788</b>	PRESBYOPIA CORRECTING FUNCTION OF INTRAOCULAR LENS
<b>V5090</b>	DISPENSING FEE, UNSPECIFIED HEARING AIDE
<b>V5095</b>	SEMI-IMPLANTABLE MIDDLE EAR HEARING PROSTHESIS
<b>V5274</b>	ASSISTIVE LEARNING DEVICE, NOT OTHERWISE SPECIFIED
<b>V5298</b>	HEARING AID, NOT OTHERWISE CLASSIFIED
<b>V5299</b>	HEARING SERVICE, MISCELLANEOUS
<b>V5336</b>	REPAIR/MODIFICATION OF AUGMENTATIVE COMMUN



Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Rev. 04/2011

DISCLAIMER: This list represents codes that are reviewed at point of claim. Under policy/guidelines, the abbreviations are as follows: ADMIN-administrative, ANC-ancillary, DME-durable medical equipment, DRUG-drugs, LAB-laboratory, MED-medicine, RAD-radiology, SURG-surgery, BEH-Behavioral Health, CG-Clinical Guideline. For details on Standard Precertification or Pharmacy Precertification requirements, please review the Pre Certification List or visit our pharmacy website (links available on the Provider Home page). Please contact customer service by calling the telephone number on the member's ID card to verify the specific requirements of the patient's plan as requirements may vary.