I. Policy: Tonsillectomy

II. Purpose/Objective:
To provide a policy of coverage regarding tonsillectomy

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

**INDICATIONS:**
Tonsillectomy may be considered medically necessary for the one or more of the following indications when criteria are met:

1. Medical record documentation of frequent episodes of tonsillitis defined as:
   - Seven or more tonsillar infections within the previous year; or
   - Five or more tonsillar infections per year in the previous 2 years; or
   - Three or more tonsillar infections per year in the previous 3 years
   and
   - Medical record documentation of at least one the following for each episode of sore throat:
     - Temperature greater than 38.3°C (100.94 °F); or
     - Cervical adenopathy; or
     - Tonsillar exudates or erythema; or
     - Positive test for Group A β-hemolytic streptococcus (GABHS).

2. A history of recurrent throat infections not meeting the criteria cited in number 1, but the member has additional factors documented in the medical record that support consideration of tonsillectomy, such as but not limited to:
   - Multiple antibiotic allergy/intolerance; or
   - PFAPA (Periodic fever, aphthous stomatitis, pharyngitis, and adenitis) syndrome; or
   - Peritonsillar or parapharyngeal abscess

3. Asymmetrical tonsillar enlargement with suspicion of potential neoplasm

4. Tonsillar hypertrophy documented by physical exam with symptomatic airway obstruction as demonstrated by the following:
   - Symptoms are chronic (more than 3 months in duration) and
     - Sleep-disordered breathing (SDB) with documentation of abnormalities of respiratory pattern or the adequacy of ventilation during sleep, including but not limited to snoring, mouth breathing, and pauses in breathing; and one of the following:
       - A condition related to SDB (including but not limited to growth retardation, poor school performance, enuresis, and behavioral problems) that is likely to improve after tonsillectomy; or
       - SDB in a child less than 3 years of age with documentation of symptoms for more than 3 months in duration and the child's parent or caregiver reports regular episodes of nocturnal choking, gasping, apnea, or breath holding; or
       - Obstructive sleep apnea as diagnosed by polysomnogram with an Apnea-Hypopnea Index (AHI) greater than 1.0 in children less than 12 years of age and AHI of 5 or greater in children age 12 years and older.

5. Tonsillectomy is proposed concurrently with adenoidectomy in children when any of the criteria 1-4 is met.

6. Tonsillectomy is proposed concurrently with uvulopalatopharyngoplasty in adults

**Note:** A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

**CODING ASSOCIATED WITH: Tonsillectomy**

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

- 42820  tonsillectomy and adenoidectomy younger than age 12
- 42821  age 12 and over
- 42825  tonsillectomy, primary or secondary, younger than age 12
LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:


This policy will be revised as necessary and reviewed no less than annually.

Devised: 1/14

Revised: 1/15 (remove auth requirement for adenoidectomy); 1/16 remove PA requirement; 1/17 (revise criteria language)

Reviewed: 1/18, 1/19