

# 2012 Tonsil & Adenoidectomy Reimbursement Fact Sheet

SURGEON CPT CODE <sup>1</sup>	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT <sup>2</sup>
42820	Tonsillectomy and adenoidectomy; age 12 years or younger	\$299
42821	Tonsillectomy and adenoidectomy; age 12 years or older	310
42825	Tonsillectomy, primary or secondary; age 12 years or younger	250
42826	Tonsillectomy, primary or secondary; age 12 years or older	259
42830	Adenoidectomy, primary; age 12 years or younger	214
42831	Adenoidectomy, primary; age 12 years or older	231
42835	Adenoidectomy, secondary; age 12 years or younger	197
42836	Adenoidectomy, secondary; age 12 years or older	248
42870	Excision or destruction lingual tonsil, any method (separate procedure)	600

## OUTPATIENT FACILITY

### Hospital Outpatient Department

APC	APC DESCRIPTION	MEDICARE PAYMENT <sup>3</sup>
0254	Tonsil and adenoid procedures (CPT codes: 42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836, 42870)	\$1,743

### Freestanding Ambulatory Surgery Center

CPT CODE	MEDICARE PAYMENT <sup>4</sup>
For CPT codes: 42820, 42870	\$1,005
For CPT code: 42821	1,005
For CPT codes: 42825, 42826, 42830, 42831, 42835, 42836	1,005

## INPATIENT FACILITY

ICD-9 CODES <sup>5</sup>	DESCRIPTION
28.2	Tonsillectomy without adenoidectomy
28.3	Tonsillectomy with adenoidectomy
28.5	Excision of lingual tonsil
28.6	Adenoidectomy without tonsillectomy
28.99	Other operations on tonsils and adenoids

**NOTE:** ICD-9 codes are grouped into Diagnoses Related Groups (DRGs) for Medicare reimbursement using a patient's diagnoses, procedures performed, age, sex and discharge status. One DRG is assigned to each inpatient stay.

DRG	DESCRIPTION	AVERAGE LENGTH OF STAY (DAYS) <sup>6</sup>	NATIONAL AVERAGE DRG PAYMENT <sup>6</sup>
133	Other ear, nose, mouth & throat O.R. procedures with CC/MCC	5.4	\$9,709
134	Other ear, nose, mouth & throat O.R. procedures without CC/MCC	2.1	4,911

1 All Current Procedural Terminology (CPT) five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines, and other material are copyright 2011 American Medical Association. All Rights Reserved.

2 Federal Register, Vol. 76, No. 228, Monday, November 28, 2011/ Rules and Regulations. The 2012 Final Physician Reimbursement Conversion Factor = \$34.0376.

3 Federal Register, Vol. 76, No. 230, Wednesday, November 30, 2011/ Rules and Regulations; Final Hospital Outpatient Payment.

4 Federal Register, Vol. 76, No. 230, Wednesday, November 30, 2011/ Rules and Regulations; Final ASC Reimbursement.

5 Hospital ICD-9-CM 2010 Volumes 1, 2 & 3, 9th Revision-Clinical Modification, American Medical Association. Copyright © 2011 Saunders, an imprint of Elsevier, Inc.

6 Federal Register, Vol. 76, No. 160, Thursday, August 18, 2011/ Rules and Regulations; Final National Average DRG Payment

Physicians should refer to their provider Carrier Manual for their geographic payments.

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