InterQual®
SmartSheets™

Authorization #
Sample Only

Procedures Criteria

Tonsillectomy (Pediatric)

PATIENT:	Name James Bond	D.O.B. 2/29/1961	ID# 9876543200	GROUP# ABCD
CPT/ICD:	Code 28.0/42820	Facility Gold Hospital	Service Date 8/20/04	
PROVIDER:	Name Dr Augustus Sample		ID# 00249	Phone# 305-555-1212
	Signature ✓ Augustus A Sample		Date 8/2/04	

ICD-9-CM: 28.2, 28.3
CPT: 42820, 42821, 42825, 42826

INDICATIONS (choose one and see below)

- ☐ **100 Peritonsillar abscess**
- ☒ **200 Chronic tonsillitis**
- ☐ **300 Recurrent acute tonsillitis**
- ☐ **400 Obstructive tonsillar hypertrophy**
- ☐ **500 Suspected tonsillar malignancy**
- ☐ **600 Tonsillar hemorrhage ♦**
- ☐ **700 Tonsillar cryptitis**
- ☐ ***Indication Not Listed (Provide clinical justification below)***

ADD ADDITIONAL CASE COMMENTS BELOW

100 Peritonsillar abscess(ONE)

- ☐ 110 Acute airway obstruction ♦
- ☐ 120 Needle aspiration contraindicated because of age
- ☐ 130 Peritonsillar abscess ⩾ 2x by Hx

200 Chronic tonsillitis(BOTH)

- ☒ 210 Sx/findings(BOTH)
  - ☒ 211 Throat pain ⩾ 6 wks by Hx
  - ☐ 212 Findings(ONE)
    - ☐ -1 Tender cervical lymph nodes
    - ☐ -2 Tonsillar erythema/exudate
    - ☒ -3 Temperature > 100.4 F
    - ☐ -4 Documented increase in tonsil size
- ☒ 220 Abx Rx ⩾ 10 days x2

300 Recurrent acute tonsillitis(BOTH)

- ☐ 310 Sx/findings during acute episode(BOTH)
  - ☐ 311 Throat pain
  - ☐ 312 Other findings(ONE)
    - ☐ -1 Tonsillar erythema/exudate by PE
    - ☐ -2 Temperature > 101 F
    - ☐ -3 Cervical lymph nodes(ONE)
      - ☐ A) Tender/enlarged
      - ☐ B) > 1.5 cm
    - ☐ -4 Documented increase in tonsil size
    - ☐ -5 Group A Beta−hemolytic strep by culture

*InterQual® criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient.

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Patient Name ID #

- ☐ 320 Frequency of documented acute episodes(ONE)
  - ☐ 321 ⩾ 3/yr for 3 yrs
  - ☐ 322 ⩾ 4/yr for 2 yrs
  - ☐ 323 ⩾ 5/yr for 1 yr

400 Obstructive tonsillar hypertrophy(ALL)

- ☐ 410 Sx/findings(ONE)
  - ☐ 411 Hyponasal/hypernasal speech
  - ☐ 412 Snoring/mouth breathing ⩾ 6 mos
  - ☐ 413 Suspected sleep apnea
  - ☐ 414 Persistent drooling
  - ☐ 415 Swallowing impairment ⩾ 6 mos **with**(ONE)
    - ☐ -1 Weight loss
    - ☐ -2 Failure to thrive
    - ☐ -3 Dysphagia with solids
- ☐ 420 3+/4+ tonsillar enlargement by PE
- ☐ 430 Normal palate by PE

500 Suspected tonsillar malignancy

600 Tonsillar hemorrhage ♦

700 Tonsillar cryptitis(ALL)

- ☐ 710 Foul breath/halitosis ⩾ 12 wks
- ☐ 720 Foul taste ⩾ 12 wks by Hx
- ☐ 730 Continued Sx/findings **after** Rx(BOTH)
  - ☐ 731 Broad spectrum Abx ⩾ 10 days x2
  - ☐ 732 Oral hygiene

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Pre-Certification Form

To avoid any delay of this review, please submit all relevant documentation with this form (dictation, progress notes, consultation requests and results).

☐ Routine ☐ Medically Urgent

Definition of Medically Urgent for Medicare members: Waiting the routine time period would seriously jeopardize the member's life, health, or the member's ability to regain maximum function.

Definition of Medically Urgent for all others: Waiting the routine time period would subject the member to severe pain that cannot be managed without the care or treatment requested.

Patient Information

Name James Bond

ID number 00249

DOB / /

Product line: ☐ Commercial ☐ Medicare

Requesting Provider Information

Provider's name Dr Augustus Sample

Phone 305-555-1212 Fax 305-555-1213

Contact name ____________________

☐ PCP request

Services requested — please attach supporting documentation

Date of service / /

Place of service (facility) ____________________

- ☐ CT scan of ____________________
- ☐ MRI of ____________________
- ☐ MRA of ____________________
- ☐ PET scan of ____________________
- ☐ Extended care referrals (chronic care)
- ☐ Dialysis
- ☐ Pain management
- ☐ Prosthetic/orthotic devices
- ☐ Sleep studies
- ☐ Out-of-area or non-participating provider
- ☐ Outpatient therapy (physical, occupational, speech, cardiac, pulmonary)
- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ Transfusion/infusion inpatient admission
- ☐ Ambulatory/outpatient surgery
- ☐ Acute rehabilitation
- ☐ Acute skilled nursing
- ☐ Hospice
- ☐ Infusion
- ☐ Drug name(s) ____________________
- ☐ Invasive vascular studies/ED studies
- ☐ Nuclear Stress Test
- ☐ Total OB care (includes one OB ultrasound performed in the physician's office between 13-24 weeks gestation)
- ☐ Additional OB ultrasound (prior to 13 weeks gestation, or after 24 weeks gestation)
- ☐ OB diagnostics
- ☐ Other ____________________

Procedure/CPT code ____________________ Primary diagnosis ____________________

Clinical information ____________________

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Physician signature ____________________ Date / /

Requests for **MEDICALLY URGENT** services: call NHP Utilization Management
SUBMIT PRE-CERTIFICATION REQUESTS TO CASE MANAGEMENT: 305-715-2421
REFERRALS: 305-715-2650 (Miami/Dade) or 1-800-550-5568/Fax: 1-800-305-0140
UM PRE-CERTIFICATION: 305-715-2468

NHP-0033-5 12/03