AMERICAN ACADEMY OF OTOLARYNGOLOGY– HEAD AND NECK SURGERY

Clinical Indicators: Adenoidectomy

Procedure	**CPT**	**Days**[1]
Adenoidectomy, primary; under age 12	42830	090
Adenoidectomy, primary; age 12 or over	42831	090
Adenoidectomy, secondary; under age 12	42835	090
Adenoidectomy secondary; age 12 or over	42836	090

Indications

1. History (One or more required)

a) Four or greater episodes of recurrent purulent rhinorrhea in prior 12 months in a child <12 years of age. One episode should be documented by intranasal examination or diagnostic imaging.
b) Persisting symptoms of adenoiditis after two courses of antibiotic therapy. One course of antibiotics should be with a B-lactamase stable antibiotic for at least two weeks.
c) Sleep disturbance with nasal airway obstruction persisting for at least 3 months.
d) Hyponasal speech.
e) Otitis media with effusion >3 months or associated with additional sets of tubes.
f) Dental malocclusion or orofacial growth disturbance documented by orthodontist or dentist.
g) Cardiopulmonary complications including cor pulmonale, pulmonary hypertension, right ventricular hypertrophy associated with upper airway obstruction.
h) Otitis media with effusion (age 4 or greater).

For infectious conditions, it is recommended that documentation of infections be obtained. For hypertrophy and other noninfectious conditions documentation should include information regarding growth, weight gain, daytime performance issues such as behavior and attention, any medical condition necessitating removal of the adenoids. Adenoid size is immaterial when the indication is sinusitis, adenoiditis, or otitis media with effusion. Allergic symptoms should have been treated with an adequate trial of allergy therapy prior to evaluation for non-infectious conditions.

2. Physical Examination (required)

a) Description of uvula, palate, tonsils, nasal airway, cervical lymph nodes.
b) Evaluation of adenoids by mirror, palpation, nasal endoscopy or imaging only as necessary.

1 RBRVS Global Days

c) Assessment for signs of hypernasal speech or risk factors for postop voice disturbance

3. Tests (If abnormality suspected by history, physical examination)

a) Coagulation and bleeding evaluation based on personal or family history
b) Radiographs (lateral neck or cephalometric)
c) Sleep tape recording (if documentation of snoring or apnea required)
d) Polysomnography in children at high risk for respiratory compromise[2]

Postoperative Observations

a) Bleeding from nose, mouth or emesis of fresh blood-notify surgeon.
b) Adequate pain control maintained postoperatively using oral medications depending on oral intake.
c) Persistent temperature >102 degrees F - notify surgeon.
d) Signs of respiratory compromise consider admission

Outcome Review

1. Two-Four Week

a) Healing - Did patient require treatment for bleeding, infections, or dehydration?
b) Function - Is there a change in voice, breathing, or swallowing from the preoperative status?

2. Long Term

a) Infection - Have there been fewer throat infections, or ear infections, if applicable?
b) Function - Is breathing improved?

Associated ICD-9 Diagnostic Codes (Representative, but not all-inclusive codes)

381.20 Chronic mucoid otitis media, simple or unspecified
382.10 Chronic tubotympanic suppurative otitis media
382.20 Chronic atticoantral otitis media
382.9 Otitis media
474.9 Chronic adenotonsillitis
474.01 Chronic Adenoiditis
474.12 Adenoid hypertrophy
474.1 Adenoid and tonsil hypertrophy
780.51 Sleep apnea

---

[2] Clinical Practice Guideline: Polysomnography for Sleep-Disordered Breathing Prior to Tonsillectomy in Children, *Otolaryngology- Head and Neck Surgery*, XX(X) 1-15 http://oto.sagepub.com/content/early/2011/06/02/0194599811409837.full.pdf+html

AMERICAN ACADEMY OF OTOLARYNGOLOGY– HEAD AND NECK SURGERY

786.09 Snoring
473.9 Chronic Sinusitis, NOS
524.4 Malocclusion

Patient Information

Removal of adenoids is one of the most frequently performed throat operations. It offers a safe, effective surgical way to resolve nasal obstruction, nasal and adenoid infections and is an adjunct to managing chronic or recurrent childhood ear disease. Pain following surgery is an unpleasant side effect, but can be controlled with medication. Similar to the pain experienced with throat infections, it may often also be felt in the ears. There are also some risks associated with removal of adenoids. Although very rare, significant postoperative bleeding may occur. If significant bleeding occurs, it is most often immediate and short lived. Treatment of such bleeding is usually handled as an outpatient; however, sustained bleeding may require treatment in the operating room under general anesthesia. In rare cases, a blood transfusion may be recommended. There are some more persistent side effects sometimes associated with the removal of adenoids. As swallowing is painful after surgery, the patient may not take in sufficient fluids orally. If this cannot be corrected at home, IV fluid replacement may be necessary. Halitosis is common in the immediate postoperative period. Infection is an infrequent occurrence. In rare cases, hypernasal speech can persist for long periods after adenoidectomy, and speech therapy and or corrective surgery may be necessary. Anesthetic complications are known to exist; however, they are quite uncommon.

Important Disclaimer Notice (Updated 8/7/14)

Clinical indicators for otolaryngology serve as a checklist for practitioners and a quality care review tool for clinical departments. The American Academy of Otolaryngology—Head and Neck Surgery, Inc. and Foundation (AAO-HNS/F) Clinical Indicators are intended as ***suggestions, not rules***, and should be modified by users when deemed medically necessary. In no sense do they represent a standard of care. The applicability of an indicator for a procedure must be determined by the responsible physician in light of all the circumstances presented by the individual patient. Adherence to these clinical indicators will not ensure successful treatment in every situation. The AAO-HNS/F emphasizes that these clinical indicators should not be deemed inclusive of all proper treatment decisions or methods of care, nor exclusive of other treatment decisions or methods of care reasonably directed to obtaining the same results. The AAO-HNS/F is not responsible for treatment decisions or care provided by individual physicians. Clinical indicators are not intended to and should not be treated as legal, medical, or business advice.

AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY