



## **Clinical Indicators: Tonsillectomy, Adenoidectomy, Adenotonsillectomy in Childhood**

<b><u>Procedure</u></b>	<b>CPT</b>	<b>Days<sup>1</sup></b>
Adeno-tonsillectomy < age 12	42820	090
Adeno-tonsillectomy > age 12	42821	090
Tonsillectomy < age 12	42825	090
Tonsillectomy > age 12	42826	090
Adenoidectomy < age 12	42830	090
Adenoidectomy > age 12	42831	090

### **Indications**

#### **1. History (one or more required)**

The guideline includes the following statements<sup>2</sup>:

- a) Watchful waiting for recurrent throat infection: Clinicians should recommend watchful waiting for recurrent throat infection if there have been fewer than 7 episodes in the past year or fewer than 5 episodes per year in the past 2 years or fewer than 3 episodes per year in the past 3 years
- b) Recurrent throat infection with documentation: Clinicians may recommend tonsillectomy for recurrent throat infection with a frequency of at least 7 episodes in the past year or at least 5 episodes per year for 2 years or at least 3 episodes per year for 3 years with documentation in the medical record for each episode of sore throat and one or more of the following: temperature >38.3°C, cervical adenopathy, tonsillar exudates, or positive test for GABHS
- c) Tonsillectomy for recurrent infection with modifying factors: Clinicians should assess the patient with recurrent throat infection who does not meet criteria in Statement 2 for modifying factors that may nonetheless favor tonsillectomy, which may include but are not limited to multiple antibiotic allergy/intolerance, PFAPA (periodic fever, aphthous stomatitis, pharyngitis, and adenitis), or history of peritonsillar abscess. parapharyngeal abscess, severe infection with dehydration requiring IV fluids, or severe infections that may aggravate comorbid conditions (eg, seizure disorder). Children who are at risk for being held back in school due to excessive absences (eg, over ten school days per academic year) may also need consideration
- d) Tonsillectomy for sleep-disordered breathing: Clinicians should ask caregivers of children with sleep-disordered breathing (SDB) and tonsil hypertrophy about comorbid conditions

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<sup>1</sup> RBRVS Global Days

<sup>2</sup> Clinical Practice Guideline, *Otolaryngology- Head and Neck Surgery*, 2011, 144:S1

<http://www.entnet.org/HealthInformation/upload/CPG-TonsillectomyInChildren.pdf>



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that might improve after tonsillectomy, including growth retardation, poor school performance, enuresis, and behavioral problems

- e) Tonsillectomy and Polysomnography: Clinicians should counsel caregivers about tonsillectomy as a means to improve health in children with abnormal polysomnography who also have tonsil hypertrophy and sleep-disordered breathing
- f) Hypertrophy\* causing dental malocclusion or adversely affecting orofacial growth documented by orthodontist, maxillofacial surgeon, or dentist
- g) Hypertrophy causing severe dysphagia (particularly when supported by swallow evaluation) or cardiopulmonary complications
- h) Peritonsillar abscess unresponsive to medical management and drainage documented by surgeon, requiring surgery performed during acute stage
- i) Persistent foul taste or breath due to chronic tonsillitis not responsive to medical therapy and for which other causes have been eliminated or treated
- j) Unilateral tonsil hypertrophy presumed neoplastic
- k) Recurrent suppurative or chronic otitis media with effusion: Adenoidectomy alone. Tonsillectomy added requires one of the indications listed above
- l) Chronic sinusitis in pediatric population not responding to maximal medical therapy (eg, appropriately chosen antibiotic, topical nasal steroid sprays, saline irrigations): Adenoidectomy alone. Tonsillectomy added requires one of the indications listed above

*\*For hypertrophy or noninfectious conditions it is recommended that history include information regarding growth and weight gain, any medical conditions necessitating removal of tonsils and adenoids, and polysomnography (optional) including hourly number of apnea or hypopnea episodes and effects of oxygen desaturations<sup>3</sup>.*

## **2. Physical Examination** (required)

- a) Description of tonsils and/or adenoids (may require x-ray or endoscopic nasopharyngoscopy for adenoid assessment)
- b) Description of uvula and palate

## **3. Tests**

- a) Coagulation and bleeding work-up if abnormality suspected by personal or family history or if the family history is unavailable
- b) Polysomnography in children at high risk for respiratory compromise (eg, under age 2, craniofacial abnormalities)<sup>4</sup>
- c) Imaging of the sinuses to document sinusitis in pediatric population if considering adenoidectomy as first surgical step for chronic rhinosinusitis. (Optional)

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<sup>3</sup> Roland PS, Rosenfeld RM, Brooks LJ, et al. Clinical practice guideline: Polysomnography for sleep-disordered breathing prior to tonsillectomy in children. *Otolaryngol Head Neck Surg.* Jul 2011;145(1 Suppl):S1-15.

<sup>4</sup> Roland PS, Rosenfeld RM, Brooks LJ, et al. Clinical practice guideline: Polysomnography for sleep-disordered breathing prior to tonsillectomy in children. *Otolaryngol Head Neck Surg.* Jul 2011;145(1 Suppl):S1-15.



### **Postoperative Observations**

- a) Bleeding from mouth, nose, or vomiting fresh blood--notify surgeon
- b) Dehydration--hydration maintained by IV until oral intake satisfactory
- c) Respiratory status monitoring in children at risk for compromise
- d) Clinicians should advocate for pain management after tonsillectomy and educate caregivers about the importance of managing pain. In concert with safe use of narcotics and sedative medications perioperatively, especially in those with SDB.

### **Outcome Review**

#### **1) Two-Four Week**

- a. Healing--Did patient require treatment for bleeding, infection, or dehydration?
- b. Function--Is there a change in voice, breathing, or swallowing?
- c. Improvement in cough and sinusitis symptoms after adenoidectomy?

#### **2) Long term**

- a. Infection--Have there been fewer throat, sinus, or ear infections, if applicable?
- b. Function--Is breathing improved? If not, consideration for polysomnography may be given
- c. Fewer requirements for antibiotics, improvement of chronic rhinosinusitis

*\*Clinicians who perform tonsillectomy should determine their rate of primary and secondary post-tonsillectomy hemorrhage at least annually<sup>5</sup>*

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

381.10	Otitis media with effusion
473.0	Chronic maxillary sinusitis (Pediatric population with chronic rhinosinusitis)
474.9	Chronic adenotonsillitis
474.00	Chronic tonsillitis
474.12	Adenoid hypertrophy
474.10	Adenoid and tonsil hypertrophy
474.11	Tonsil hypertrophy
475	Peritonsillar abscess
780.51	Sleep apnea
786.09	Snoring

### **Patient Information**

Removal of tonsils and/or adenoids is one of the most frequently performed throat operations. It has proven to be a safe, effective surgical method to resolve breathing obstruction, throat

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<sup>5</sup> Tonsillectomy guideline statement 10: Posttonsillectomy hemorrhage:



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infections and manage recurrent childhood ear disease. Pain following surgery is an unpleasant side effect, which can be reasonably controlled with medication. It is similar to the pain patients have experienced with throat infections, but often is also felt in the ears after surgery. There are also some risks associated with removal of tonsils and/or adenoids. Post operative bleeding occurs in about .1% to 3% of cases, most often 5-10 days after surgery, although it can occur at any time during the first 2 weeks after surgery. Treatment of bleeding sometimes requires control in the operating room under general anesthesia. In rare cases, a blood transfusion may be recommended. Because swallowing is painful after surgery, there may be poor oral intake of fluids. If this cannot be corrected at home, the patient may be admitted to the hospital for IV fluid replacement. Respiratory difficulties may occur in young children, children with severe obstructive apnea, and children with anatomic or physiologic respiratory co-morbidities. These children should be monitored closely after surgery for extended periods. Anesthetic complications are known to exist; they are quite uncommon, however, since patients are usually young and healthy.

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