Anthem

Clinical UM Guideline

Subject: Tonsillectomy for Children with or without Adenoidectomy
Guideline #: CG-SURG-30
Status: Reviewed

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Description

This document addresses tonsillectomy in children with or without adenoidectomy. This surgery has been widely accepted as a treatment method for children with recurrent throat infections, tonsil hypertrophy and sleep-disordered breathing (SDB), and obstructive sleep apnea (OSA).

Note: This document does not address adenoidectomy separate from tonsillectomy.

Note: For information regarding related procedures, please see:

- CG-SURG-36 Adenoidectomy
- CG-SURG-46 Myringotomy and Tympanostomy Tube Insertion
- CG-SURG-113 Tonsillectomy with or without Adenoidectomy for Adults
- SURG.00129 Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring

Clinical Indications

Medically Necessary:

Tonsillectomy is considered **medically necessary** for individuals less than 18.0 years of age who meet one or more of the criteria below:

A. A history of recurrent throat infection with a frequency of at least:
   1. Seven episodes in the past year; **or**
   2. Five episodes per year for 2 years; **or**
   3. Three episodes per year for 3 years;
      and
   4. Documentation in the medical record for each episode of sore throat which includes at least one of the following:
      a. Temperature greater than 38.3 °C (100.9 °F);**or**
      b. Cervical adenopathy; **or**
      c. Tonsillar exudates or erythema; **or**
      d. Positive test for Group A β-hemolytic streptococcus (GABHS).
      or

B. A history of recurrent throat infections not meeting criteria above, but individual has additional factors that favor tonsillectomy, including but not limited to:
   1. Multiple antibiotic allergy/intolerance; **or**
   2. Periodic fever, aphthous stomatitis, pharyngitis, and adenitis (PFAPA) syndrome;**or**
   3. Peritonsillar abscess; **or**
   4. Two or more parapharyngeal abscesses.
      or

C. A diagnosis of sleep-disordered breathing (SDB) with documentation of the following:
   1. Tonsillar hypertrophy and either of the following:
      a. Abnormalities of respiratory pattern or the adequacy of ventilation during sleep, including but not limited to snoring, mouth breathing, and pauses in breathing*; **or**
      b. A condition related to SDB (including but not limited to growth retardation, poor school performance, enuresis, asthma, and behavioral problems) that is likely to improve after tonsillectomy.
      or

D. A diagnosis of SDB for a child less than 3 years of age with documentation of all of the following:
   1. Tonsillar hypertrophy; **and**
   2. SDB is chronic (more than 3 months in duration);**and**
   3. Child's parent or caregiver reports regular episodes of nocturnal choking, gasping, apnea, or breath holding.
      or

E. A diagnosis of obstructive sleep apnea (OSA) with documentation of all of the following:
   1. Tonsillar hypertrophy; **and**
   2. A polysomnogram with an Apnea-Hypopnea Index (AHI) greater than 1.0.
      or

F. Suspicion of tonsillar malignancy.

***Note:** Documentation of SDB can be made on the basis of physical and history only, and does not require polysomnography. A history of snoring alone is not sufficient to make a diagnosis of SDB.

Not Medically Necessary:

Tonsillectomy is considered **not medically necessary** for children less than 18.0 years of age when the criteria above have not been met, and in all other circumstances.

Coding

The following codes for treatments and procedures applicable to this guideline are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

When services are Medically Necessary:

CPT

42820	Tonsillectomy and adenoidectomy; younger than age 12
42821	Tonsillectomy and adenoidectomy; age 12 or over
42825	Tonsillectomy, primary or secondary, younger than age 12
42826	Tonsillectomy, primary or secondary, age 12 or over

ICD-10 Procedure

0CTP0ZZ	Resection of tonsils, open approach
0CTPXZZ	Resection of tonsils, external approach

ICD-10 Diagnosis

C09.0-C09.9	Malignant neoplasm of tonsil
D00.08	Carcinoma in situ of pharynx
D37.05	Neoplasm of uncertain behavior of pharynx

When services may be Medically Necessary when criteria are met:
For the procedure codes listed above for the following diagnoses

ICD-10 Diagnosis

A49.1	Streptococcal infection, unspecified site
B99.8-B99.9	Other and unspecified infectious diseases
G47.30-G47.39	Sleep apnea
J02.0-J02.9	Acute pharyngitis
J03.00-J03.91	Acute tonsillitis
J31.1	Chronic nasopharyngitis
J31.2	Chronic pharyngitis
J35.01-J35.9	Chronic diseases of tonsils and adenoids
J36	Peritonsillar abscess
J39.0-J39.9	Other diseases of upper respiratory tract
P28.30-P28.49	Primary/other sleep apnea of newborn
R06.5	Mouth breathing
R06.81-R06.89	Other abnormalities of breathing
Z87.09	Personal history of other diseases of the respiratory system

When services are Not Medically Necessary:
For the procedure and diagnosis codes listed above when criteria are not met or for all other diagnoses not listed.

Discussion/General Information

Tonsillectomy is one of the most common surgical procedures in the United States, with more than 530,000 procedures performed annually in children younger than 15 years of age. Tonsillectomy is defined as a surgical procedure performed with or without adenoidectomy that completely removes the tonsil including its capsule by dissecting the peritonsillar space between the tonsil capsule and the muscular wall. Depending on the context in which it is used, it may indicate tonsillectomy with adenoidectomy, especially in relation to sleep-disordered breathing (SDB). Indications for surgery include recurrent throat infections and SDB, both of which can substantially affect child health status and quality of life. Although there are benefits of tonsillectomy, complications of surgery may include throat pain, postoperative nausea and vomiting, delayed feeding, voice changes, post-tonsillectomy hemorrhage (PTH), and rarely death.

The American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS) has a clinical practice guideline addressing the use of tonsillectomy in children (Mitchell, 2019). In this guideline, they recommend the following:

1. STATEMENT 2: 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, 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 1 or more of the following: temperature >38.3^{o}C (101^{o}F), cervical adenopathy, tonsillar exudate, or positive test for group A beta-hemolytic streptococcus.
2. STATEMENT 3. TONSILLECTOMY FOR RECURRENT INFECTION WITH MODIFYING FACTORS:
   Clinicians should assess the child with recurrent throat infection who does not meet criteria in Key Action 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 > 1 peritonsillar abscess.
3. STATEMENT 4. TONSILLECTOMY FOR OBSTRUCTIVE SLEEP-DISORDERED BREATHING:
   Clinicians should ask caregivers of children with obstructive sleep disordered breathing (oSDB) and tonsil hypertrophy about comorbid conditions that might improve after tonsillectomy, including growth retardation, poor school performance, enuresis, asthma, and behavioral problems.
4. STATEMENT 7. TONSILLECTOMY FOR OBSTRUCTIVE SLEEP APNEA:
   Clinicians should recommend tonsillectomy for children with obstructive sleep apnea (OSA) documented by overnight polysomnography (PSG). Recommendation based on randomized controlled trial and observational before-and-after studies with a preponderance of benefit over harm.

It should be noted that the AAO-HNS guideline states the following:

> The guideline does not apply to populations of children excluded from most tonsillectomy research studies, including those with neuromuscular disease, diabetes mellitus, chronic cardiopulmonary disease, congenital anomalies of the head and neck region, coagulopathies, or immunodeficiency.

These recommendations are widely accepted as the standard of care for this procedure in children and are supported by extensive clinical trial data (Blakley, 2009; Brietzke, 2006; Friedman, 2009; Garavello, 2009; Paradise, 2002; Stewart, 2005; Tauman, 2006; van Staaij, 2004).

The most frequent indication for tonsillectomy is recurrent throat infection. According to the AAO-HNS, a throat infection is defined as sore throat caused by viral or bacterial infection of the pharynx, palatine tonsils, or both, which may or may not be culture positive for group A streptococcus. This includes strep throat infection and acute tonsillitis, pharyngitis, adenotonsillitis, or tonsillopharyngitis. The

symptoms of a throat infection vary due to the root cause, but may include scratchy sensation in the throat; dry throat; white patches or pus on the tonsils; redness and inflammation of the larynx, pharynx, or tonsils; swollen or sore glands of the neck and jaw; and pain when swallowing or speaking. The treatment methods used to address throat infections will depend upon the cause of the infection, but medications such as antibiotics and anti-inflammatory drugs to treat infection and alleviate symptoms are common. When an individual has frequent throat infections despite optimal treatment, the use of surgical interventions such as tonsillectomy may be warranted.

SDB is the second most common indication for tonsillectomy in children and is characterized by disturbances in breathing pattern or efficacy during sleep. Unfortunately, there is no widely accepted standard for the diagnosis of SDB. However, it is recognized that SDB may involve snoring, mouth breathing, and pauses in breathing (apnea). However, the use of snoring as a criterion for the diagnosis of SDB should be used carefully, as the AAO-HNS states, “The presence or absence of snoring neither includes nor excludes SDB, as not all children who snore have SDB, and caregivers may not observe intermittent snoring that occurs during the night.” (Baugh, 2011). Daytime symptoms associated with SDB may include excessive sleepiness, inattention, poor concentration, aggression, depression, hyperactivity, and wetting the bed. A wide array of obstructive disorders may result in SDB, ranging in severity from simple snoring to obstructive sleep apnea. The most common cause of SDB in children is tonsillar hypertrophy, which is an abnormal enlargement of the tonsils. This may be due to chronic infection or excess tissue growth. Diagnosis of SDB may be based on an individual’s medical history, physical examination, audio/video taping, pulse oximetry, or limited or full-night polysomnogram, also known as a sleep test. History and physical examination are the most common initial methods for diagnosis. Treatment may involve antibiotics to address underlying infection, but if such treatment fails or is not indicated, tonsillectomy may be warranted.

In children under 3 years of age, behavioral issues related to SDB may be more difficult to identify (for example, they may not yet be continent and, as such, enuresis would not necessarily be a sign of SDB). In addition, access to diagnostic polysomnography may be difficult and the results may be less reliable. Based on additional clinical input from specialists in the field, it would be appropriate to consider tonsillectomy when a parent or caregiver reports regular episodes of nocturnal choking, gasping, apnea, or breath holding which have persisted for several months in the setting of documented tonsillar hypertrophy.

OSA is a major subset of SDB. Individuals with OSA suffer from redundant soft tissue in the pharynx, including the adenoids and tonsils, which block the upper airway leading to periodic cessation of breathing. Individuals with OSA must change sleep position or increase their respiratory effort to overcome the blockage, disrupting sleeping patterns. Symptoms of OSA may include nocturnal gasping, cyanosis, excessive daytime sleepiness, pulmonary hypertension, and snoring, to name just a few. The diagnosis of OSA in children has not been standardized, although there is some consensus that a threshold of greater than one on the Apnea-Hypopnea Index (AHI) is an indication of OSA (Au, 2009; Chan, 2004; Spruyt, 2012). Both the American Academy of Pediatrics (AAP; Burns, 2017; Marcus, 2012) and AAO-HNS (Baugh, 2011) regard tonsillectomy as a reasonable option for any child with documented OSA.

In 2013, Marcus et al. published results of a single-blind randomized controlled trial (RCT), the Childhood Adenotonsillectomy Trial (CHAT). This trial involved 464 children, 5 to 9 years of age, with OSA, 400 of whom completed the trial (86%). Subjects were randomized to either watchful-waiting (n=203) or early adenotonsillectomy (n=194) and followed for 7 months after randomization. The primary outcome, the attention and executive function score on the Developmental Neuropsychological Assessment, did not differ significantly at follow-up (p=0.16). However, the authors reported that there were significantly greater improvements in behavioral, quality-of-life, and polysomnographic findings and significantly greater reduction in symptoms in the early-adenotonsillectomy group vs. the watchful-waiting group. Furthermore, normalization of polysomnographic findings was observed in a larger proportion of subjects in the early-adenotonsillectomy group than in the watchful-waiting group (79% vs. 46%). They conclude that their findings provide evidence of beneficial effects of early adenotonsillectomy.

A secondary analysis of the CHAT trial was published in 2021 by Gourishetti and colleagues. The question they sought to answer was whether the AHI threshold chosen as an indication of OSA is predictive of post-adenotonsillectomy changes. Neurocognition, behavior, symptoms of OSA and quality of life were measured at baseline and at the 7 month follow-up after grouping children based on whether their AHI was greater than or equal to 5. The authors found that these outcomes did not differ in children randomized to watchful waiting or to adenotonsillectomy based on the OSA severity threshold alone. The effects of adenotonsillectomy on post-treatment outcomes also were not different based on AHI threshold. These results highlight the limited utility of AHI in measuring the severity of OSA and the importance of preoperative history and physical examination in guiding treatment of OSA.

In another secondary analysis of CHAT trial data, Castro-Rodriguez and colleagues (2023) found that adenotonsillectomy decreased the risk of wheezing at 7 months of follow-up. In children in the adenotonsillectomy arm, the prevalence of wheezing significantly decreased from baseline to follow-up (47% vs. 21.6%, $p < 0.001$) but did not change in the watchful-waiting arm (45.2% vs. 43.1%, $p = 0.67$). When the children were grouped by having “any wheezing” versus “no wheezing”, a multivariate analysis found that socioeconomic factors influenced the risk of wheezing. Children in the “any wheezing” group had more eczema, second-hand smoke exposure, allergic rhinitis, body mass index, higher AHI and had lower maternal education and family income than those in the “no wheezing” group.

In 2017 the Agency for Healthcare Research and Quality (AHRQ) published a comparative effectiveness review titled *Tonsillectomy for obstructive sleep-disordered breathing or recurrent throat infection in Children*. This document concluded the following:

> Tonsillectomy can produce short-term improvement in sleep outcomes and reduction in throat infections compared with no surgery in children with OSDB or recurrent throat infections. Relative to no intervention, most studies reported better sleep-related outcomes in children with OSDB who had a tonsillectomy, but longer term data on durability of outcomes are limited. Children undergoing tonsillectomy to improve number of throat infections, associated health care utilization (clinician visits), and work/school absences had improvements in these outcomes in the first postsurgical year compared with children not receiving surgery. These benefits did not persist over time, and data on longer-term results are lacking. This short-term improvement must be weighed against a roughly 4 percent frequency of PTH.

Byars and others (2018) conducted a population-based cohort study of 1,189,061 children. Subjects included both controls and those who underwent adenoidectomy, tonsillectomy, and adenotonsillectomy in Denmark between 1979 and 1999. Data for these subjects were linked to national registers up to 2009, covering at least the first 10 and up to 30 years of life. There were 17,460 subjects who underwent adenoidectomy, 11,830 who underwent tonsillectomy, and 31,377 who underwent adenotonsillectomy. The control group included 1,157,684 subjects who did not undergo those procedures. The authors reported that “adenoidectomy and tonsillectomy were associated with a 2- to 3-fold increase in diseases of the upper respiratory tract (relative risk [RR], 1.99 and RR, 2.72, respectively).” Smaller increases in risks for infectious and allergic diseases were also found, including that adenotonsillectomy was associated with a 17% increased risk of infectious diseases (RR, 1.17), corresponding to an absolute risk increase of 2.14%. They concluded by suggesting, “It is important to consider long-term risks when making decisions to perform tonsillectomy or adenoidectomy.”

Definitions

Adenitis: A general term for an inflammation of a gland or lymph node.

Adenoids: Organs of the lymphatic system located in the nasal cavity above the roof of the mouth. The purpose of the adenoids is to capture germs entering the body through the mouth and nose.

Aphthous stomatitis: Recurrent small painful oral ulcers thought to be due to local dysregulation of cell-based immunity.

Apnea-Hypopnea index (AHI) or Respiratory Disturbance index (RDI): A measure of apnea severity defined by the total number of episodes of apnea or hypopnea during a full period of sleep divided by the number of hours asleep.

Cervical adenopathy: Enlargement of the cervical lymph nodes, located on both sides of the neck.

Group A β-hemolytic streptococcus (GABHS): A bacteria commonly associated with serious throat infections in children.

Obstructive sleep apnea: A condition which is characterized by cessation of breathing during sleep, caused by temporary collapse of the upper airway.

Pharyngitis: The medical term for a “sore throat.”

PFAPA: A medical condition characterized by recurrent episodes of periodic fever, aphthous stomatitis, pharyngitis, and adenitis.

Polysomnography: Also known as a “sleep study.” A test used to diagnose sleep disorders.

Sleep-disordered breathing (SDB): A group of disorders characterized by abnormalities of breathing pattern or the quantity of breathing during sleep.

Tonsils: Organs of the lymphatic system located at the back of the throat. The purpose of the tonsils is to capture germs entering the body through the mouth and nose.

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Peer Reviewed Publications:

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Government Agency, Medical Society, and Other Authoritative Publications:

1. Agency for Healthcare Research and Quality (AHRQ). Comparative effectiveness review number 183. Tonsillectomy for obstructive sleep-disordered breathing or recurrent throat infection in Children. January 17, 2017. Available at: https://www.ncbi.nlm.nih.gov/books/NBK424048/. Accessed on November 7, 2023.
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Websites for Additional Information

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2. National Library of Medicine. Tonsillectomies and children. Available at: http://www.nlm.nih.gov/medlineplus/ency/article/001998.htm. Accessed on November 7, 2023.

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The use of specific product names is illustrative only. It is not intended to be a recommendation of one product over another, and is not intended to represent a complete listing of all products available.

History

Status	Date	Action
Reviewed	02/15/2024	Medical Policy & Technology Assessment Committee (MPTAC) review. Revised Discussion/General Information, References and Websites for Additional Information sections.
Reviewed	02/16/2023	MPTAC review. Updated Discussion/General Information, References and Websites for Additional Information sections.
	09/28/2022	Updated Coding section with 10/01/2022 ICD-10-CM changes; added P28.30-P28.49 replacing P28.3-P28.4.
Reviewed	02/17/2022	MPTAC review. Updated References and Websites sections.
Reviewed	02/11/2021	MPTAC review. Updated References and Websites sections. Reformatted Coding section; added specific ICD-10 diagnosis codes.
Reviewed	02/20/2020	MPTAC review. Updated References and Websites sections.
Revised	03/21/2019	MPTAC review. Minor clarifications made to MN criteria A1, A1, and A3. Revised MN criteria B4 to say “History of one or more”. Added “asthma” as potential condition improved by tonsillectomy in MN criteria C1b. Updated Discussion and References sections.
Reviewed	05/03/5018	MPTAC review. The document header wording updated from “Current Effective Date” to “Publish Date.” Updated Description and References sections.
Reviewed	05/04/5017	MPTAC review. Updated Formatting in Clinical Indications Section. Updated, Rationale, Definitions, and References sections.
Revised	05/25/2016	Clarified MN criteria C regarding sleep disordered breathing criteria to indicate that documentation of tonsillar hypertrophy and either of the conditions in the two sub-bullets is required.
Revised	05/05/2016	MPTAC review. Clarified MN criteria regarding sleep disordered breathing criteria. Updated References section.
Reviewed	11/05/2015	MPTAC review. Updated References section. Removed ICD-9 codes from Coding section.
Reviewed	11/13/2014	MPTAC review. Updated title to include “with or without Adenoidectomy”. Updated Discussion and References sections.
Reviewed	11/14/2013	MPTAC review. Updated Discussion and References sections.
Revised	11/08/2012	MPTAC review. Added additional criteria for the diagnosis for sleep disordered breathing. Added medically necessary criteria for obstructive sleep apnea. Added medically necessary criteria for the diagnosis of SDB in children less than 3 years. Updated Discussion, Definitions and References sections.
Revised	08/09/2012	MPTAC review. Clarified age criteria in the position statement.
New	02/16/2012	MPTAC review. Initial document development.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to adopt a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan’s or line of business’s members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

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