

2015 Procedures Criteria

PATIENT:	Name	DOB	ID#	GROUP#
	Facility Service Date			
PROVIDER:	Name		Fax#	Phone#
	Signature		Date	NPI/ID#
ICD-9:				
CPT®:				
Subset: Ton:	sillectomy (Pediatric) ^(1, 2, 3)			
Requested Service: Tonsillectomy (Pediatric)				
Age: Age < 18				
INSTRUCTIONS: Choose one of the following options and continue to the appropriate section				
10. Chronic tonsillitis				
□ 20. Obstructive sleep apnea syndrome (OSAS)				
□ 30. Peritonsillar abscess				
□40. Recurrent acute tonsillitis				
□ 50. Symptomatic tonsillar hypertrophy				
□ 60. Tonsillar malignancy				
🗌 70. Tons	illolithiasis			

🗌 10. Chronic tonsillitis

1. Sore throat \geq 12 weeks⁽⁴⁾

🗌 Yes

🗌 No

If option Yes selected, then go to question 2

· No other options lead to the requested service

2. Choose all that apply:

- □ A) Tonsillar hypertrophy
- B) Tonsillar erythema or exudate by physical examination
- □ C) Tender cervical lymph nodes
- D) Other clinical information (add comment)
- If 1 or more options A, B or C selected and option D not selected, then go to question 3
- · No other options lead to the requested service

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- 3. Continued symptoms or findings after antibiotics \geq 10 days
 - 🗌 Yes
 - 🗌 No
 - If option Yes selected, then the rule is satisfied; you may stop here (Outpatient)
 - No other options lead to the requested service

\square 20. Obstructive sleep apnea syndrome (OSAS)

- 1. Obstructive sleep apnea syndrome diagnosed by, Choose one:⁽⁵⁾
 - \square A) Symptoms and findings
 - □ B) Polysomnogram (PSG)⁽⁶⁾
 - \Box C) Other clinical information (add comment)
 - If option A selected, then go to question 2
 - If option B selected, then go to question 4
 - No other options lead to the requested service

2. Snoring \geq 3 nights per week⁽⁷⁾

- 🗌 Yes
- 🗌 No
- If option Yes selected, then go to question 3
- No other options lead to the requested service
- 3. Choose all that apply:
 - $\hfill\square$ A) Labored breathing or gasping or choking during sleep
 - \square B) Witnessed apneic episodes during sleep⁽⁸⁾
 - C) Sleep enuresis⁽⁹⁾
 - \Box D) Excessive daytime sleepiness^(10, 11)
 - □ E) Documented behavioral problems or learning problems⁽¹²⁾
 - □ F) Other clinical information (add comment)
 - If 1 or more options A, B, C, D or E selected and option F not selected, then go to question 4
 - No other options lead to the requested service

4. Choose all that apply:

- □ A) Tonsillar hypertrophy by physical examination
- \square B) Normal palate by physical examination
- C) Other clinical information (add comment)



20. Obstructive sleep apnea syndrome (OSAS) (Continued...)

- If the number of options selected is 2 and option C not selected, then the rule is satisfied; you may stop here
- No other options lead to the requested service

30. Peritonsillar abscess

1. Choose one:⁽¹³⁾

- \square A) Acute airway obstruction (urgent)⁽¹⁴⁾
- \square B) Needle aspiration or incision and drainage unsuccessful or not feasible⁽¹⁵⁾
- □ C) Recurrent peritonsillar abscess⁽¹⁶⁾
- \Box D) History of peritonsillar abscess and recurrent or chronic tonsillitis⁽¹⁷⁾
- □ E) Other clinical information (add comment)
- If option A, B, C or D selected, then the rule is satisfied; you may stop here
- No other options lead to the requested service

□ 40. Recurrent acute tonsillitis

1. Choose one:

- \Box A) Recurrent episodes of acute tonsillitis⁽¹⁸⁾
- \square B) Periodic fevers with apthous stomatitis, pharyngitis, and adenititis (PFAPA)^(19, 20)
- □ C) Other clinical information (add comment)
- If option B selected, then the rule is satisfied; you may stop here (Outpatient)
- If option A selected, then go to question 2
- No other options lead to the requested service

2. Choose one: (21, 22)

- \square A) \ge 3 documented episodes per year for 3 years
- \square B) \ge 5 documented episodes per year for 2 years
- \Box C) \geq 7 documented episodes per year for 1 year
- □ D) Other clinical information (add comment)
- If option A, B or C selected, then the rule is satisfied; you may stop here
- No other options lead to the requested service

50. Symptomatic tonsillar hypertrophy

1. Choose all that apply:

- □ A) Hyponasal speech \geq 12 weeks⁽²³⁾
- \square B) Snoring or mouth breathing \ge 12 weeks
- □ C) Dysphagia \geq 12 weeks⁽²⁴⁾
- □ D) Other clinical information (add comment)



50. Symptomatic tonsillar hypertrophy (Continued...)

- If 1 or more options A, B or C selected and option D not selected, then go to question 2
- No other options lead to the requested service
- 2. Choose all that apply:
 - □ A) Tonsillar hypertrophy by physical examination
 - □ B) Normal palate by physical examination
 - □ C) Other clinical information (add comment)
 - If the number of options selected is 2 and option C not selected, then the rule is satisfied; you may stop here
 - No other options lead to the requested service

□ 60. Tonsillar malignancy

1. Choose one:

- □ A) Suspected tonsillar malignancy⁽²⁵⁾
- □ B) Known tonsillar malignancy
- C) Other clinical information (add comment)
- If option A selected, then go to question 2
- If option B selected, then go to question 3
- · No other options lead to the requested service

2. Choose all that apply:

- □ A) Unilateral tonsillar enlargement or tonsillar asymmetry
- □ B) Abnormal appearance of tonsil
- C) Other clinical information (add comment)
- If 1 or more options A or B selected and option C not selected, then the rule is satisfied; you may stop here
- No other options lead to the requested service

3. Choose one:

- □ A) Tonsillar malignancy by biopsy
- □ B) Fine needle aspiration (FNA) positive for malignancy
- □ C) Other clinical information (add comment)
- If option A or B selected, then the rule is satisfied; you may stop here
- No other options lead to the requested service

☐ 70. Tonsillolithiasis

1. Choose all that apply:



□ 70. Tonsillolithiasis (Continued...)

- \square A) Chronic tonsillitis with tonsilloliths \ge 12 weeks
- \Box B) Continued symptoms or findings after oral hygiene⁽²⁶⁾
- □ C) Other clinical information (add comment)
- If the number of options selected is 2 and option C not selected, then the rule is satisfied; you may stop here
- No other options lead to the requested service



Notes

(1)

I/O Setting:
Child < 3 years of age - Inpatient or Outpatient
Obstructive sleep apnea syndrome (OSAS) - Inpatient or Outpatient
Peritonsillar abscess - Inpatient or Outpatient
Tonsillar malignancy - Inpatient or Outpatient
All others - Outpatient

(2)

Day surgery with overnight observation in the hospital is recommended for children less than three years of age or for those who have severe obstructive sleep apnea syndrome (OSAS) (Roland et al., Otolaryngol Head Neck Surg 2011, 145: S1-15). For children with mild to moderate OSAS, there is less guidance. Recent retrospective analyses of pediatric patients undergoing tonsillectomy or adenotonsillectomy with mild to moderate OSAS found that patients without comorbidities experienced low risk of respiratory complications (Baguley et al., Int J Pediatr Otorhinolaryngol 2014, 78: 71-4; Cooper et al., Int J Pediatr Otorhinolaryngol 2013, 77: 1877-80; Rodman et al., Int J Pediatr Otorhinolaryngol 2013, 77: 682-5). Pediatric patients with comorbidities that include Down syndrome, neuromuscular problems, cardiovascular disease, pulmonary disease, craniofacial abnormalities, mucopolysaccharoidoses, hemoglobinopathy, and morbid obesity have a significantly higher risk for requiring an unplanned intensive care unit admission after tonsillectomy when compared with healthy children (Tweedie et al., Int J Pediatr Otorhinolaryngol 2012, 76: 809-15). Careful selection of patients for day surgery is an essential component of the preoperative assessment.

(3)

InterQual® criteria are derived from the systematic, continuous review and critical appraisal of the most current evidence-based literature and include input from our independent panel of clinical experts. The content is based on a variety of references which are cited at specific criteria points throughout the subset.

(4)

Chronic tonsillitis is defined as symptoms lasting for at least 12 weeks.

(5)

The diagnosis of obstructive sleep apnea syndrome (OSAS) in children is based on history, physical examination, and polysomnogram (PSG). PSG is considered the standard in evaluating the presence and severity of pediatric OSAS. Whether PSG is routinely needed in children with anatomic causes of their symptoms (e.g., tonsillar or adenoid hypertrophy) continues to be debated. There are currently no universally accepted standards for scoring respiratory events in children. Objective testing can minimize the risk of overtreatment and can also assist in directing the patient to appropriate treatment options (Lescanne et al., Eur Ann Otorhinolaryngol Head Neck Dis 2012, 129: 264-71; Marcus et al., Pediatrics 2012, 130: e714-55; Aurora et al., Sleep 2011, 34: 379-88; Baugh et al., Otolaryngology-Head and Neck Surgery 2011, 144: S1-S30; Wise et al., Sleep 2011, 34: 389-98AW).

(6)

Current guidelines recommend that patients with obesity, craniofacial abnormalities, neuromuscular disorders, Down syndrome, sickle cell disease, mucopolysaccharoidoses, or for whom the diagnosis is in question should undergo a polysomnogram prior to tonsillectomy (Roland et al., Otolaryngol Head Neck Surg 2011, 145: S1-15).

(7)

All children who snore do not have obstructive sleep apnea syndrome (OSAS); however, habitual snoring is nearly universally observed in children with confirmed sleep-disordered breathing. When snoring occurs three or more nights per week, further evaluation is warranted. A polysomnogram can definitively distinguish between primary snoring and OSAS (Marcus et al., Pediatrics 2012, 130: e714-55).

(8)

Apnea occurs when a patient's breathing nearly or completely stops for periods of ten seconds or more.

(9)

There is an associated risk for obstructive sleep apnea syndrome in children with sleep enuresis who have been otherwise continent for at least six months (Marcus et al., Pediatrics 2012, 130: e714-55; Barone et al., Pediatrics 2009, 124: e53-9).

(10)

Excessive daytime sleepiness is characterized by daytime sleepiness with inappropriate or irresistible naps throughout the day. Patients may complain of the inability to function at optimum levels during the day, have difficulty concentrating, or may perform poorly at work or school. This degree of sleepiness interferes with ADLs.

(11)



Excessive daytime sleepiness may occur in young children; however, it is relatively uncommon in children with obstructive sleep apnea syndrome (Tan et al., Nat Sci Sleep 2013, 5: 109-23; Marcus et al., Pediatrics 2012, 130: e714-55).

(12)

Behavioral or cognitive problems may be associated with mild to moderate obstructive sleep apnea syndrome (OSAS) and can manifest as attention deficit hyperactivity disorder (ADHD) or the inability to concentrate. A recent meta-analysis found that a relationship exists between sleep disordered breathing and ADHD symptoms and improvement was found in the ADHD symptoms after tonsillectomy (Sedky et al., Sleep Med Rev 2014, 18: 349-56). Additionally, poor grades, sleepiness, inattention, hyperactivity, and oppositional behaviors have also been associated with OSAS (Beebe, Pediatr Clin North Am 2011, 58: 649-65).

(13)

The management of peritonsillar abscess (PTA) includes intravenous antibiotics, steroids, needle aspiration, incision and drainage (I &D), and tonsillectomy, as well as symptomatic relief of accompanying pain and dehydration (Albertz and Nazar, Acta Otolaryngol 2012, 132: 1102-7; Wang, Pediatr Neonatol 2012, 53: 325-6). When PTA is treated with needle aspiration or I &D, the need for subsequent tonsillectomy is about 10% to 20% (Baugh et al., Otolaryngology-Head and Neck Surgery 2011, 144: S1-S30). Because of the high recurrence rate, some clinicians advocate for interval tonsillectomy (e.g., done at a later date after infection has cleared), while others offer a Quinsy tonsillectomy, which is done at presentation of PTA, to prevent future episodes of PTA or tonsillitis (Simon et al., Int J Pediatr Otorhinolaryngol 2013, 77: 1355-8).

(14)

Urgent conditions do not require preauthorization. A review to determine the appropriateness of the intervention is generally performed following the intervention.

(15)

Needle aspiration cannot be safely performed in a very young or uncooperative child.

(16)

The patient with a history of recurrent peritonsillar abscesses is at risk for additional abscesses. This history justifies tonsillectomy (Baugh et al., Otolaryngology-Head and Neck Surgery 2011, 144: S1-S30).

(17)

A recently published national cohort study of patients with peritonsillar abscess reported a recurrence rate of 6.7 % of patients less than 30 years of age and 2% of patients greater than 30 years of age. Patients with recurrent peritonsillar abscess were significantly more likely to have a history of prior tonsillitis when compared with those without a history of tonsillitis. Patients with more than five prior episodes had the greatest increased risk but the increase was also observed in patients with one to four episodes of prior tonsillitis (Wang et al., PLoS One 2014, 9: e109887).

(18)

A patient with an acute episode of tonsillitis would be expected to have enlarged tonsils with erythema or exudate on physical examination, fever, cervical adenopathy, or Group A Beta hemolytic strep by culture.

(19)

The most common recurrent fever syndrome in childhood is 'periodic fevers, with apthous stomatitis, pharyngitis, and adenitis' (PFAPA). The onset of disease is typically before age five and resolves by adolescence. Children with PFAPA will typically experience episodes of fever that last for three to six days and recur every three to eight weeks. During an acute episode, patients typically experience fever, sore throat, cervical adenopathy, and apthous stomatitis (canker sore). In between episodes, children are well and experience normal growth and development. The treatment of PFAPA is still debated but includes symptom relief, corticosteroids, and tonsillectomy (Vigo and Zulian, Autoimmun Rev 2012, 12: 52-5).

(20)

A meta-analysis of tonsillectomy for the treatment of 'periodic fever, apthous stomatitis, pharyngitis, and adenitis' (PFAPA) concluded that tonsillectomy may be a useful treatment option (Burton et al. Tonsillectomy for PFAPA. Cochrane Database of Systematic Reviews. 2010. Issue 9). Several recent otolaryngology guidelines also recommend tonsillectomy as an option for the treatment of PFAPA (Lescanne et al. European Annals of Otorhinolaryngology, Head and Neck (2012). 129, 264-271; Baugh et al. Otorhinolaryngology-Head and Neck Surgery (2011). 144(IS) S1-S30). PFAPA is a self-limiting disease process and, as such, the decision to undergo surgery should be considered in respect to risks of the procedure and overall severity of the illness.

(21)

The American Academy of Otolaryngology-Head and Neck Surgery guidelines for tonsillectomy in children recommend the same frequency of episodes of recurrent tonsillitis as the Children's Hospital of Pittsburgh studies when planning a tonsillectomy. These episodes must be documented in the medical record. If there are fewer documented episodes, watchful waiting is recommended (Baugh et al., Otolaryngology-Head and Neck Surgery 2011, 144: S1-S30).

(22)

The frequencies listed here are guidelines. The decision to perform tonsillectomy must be based on factors such as the severity of each episode and the impact upon the family and child in terms of behavior and lost school time

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(23)

Hyponasal or hypernasal speech refers to the muffled, garbled, hot-potato voice that is caused by significantly enlarged tonsils and adenoids. It may also occur with peritonsillar hypertrophy or a hypopharyngeal or laryngeal process. Patients with isolated adenoid hypertrophy more commonly present with hyponasal speech (Benninger and Walner, Clin Cornerstone 2007; 9 Suppl 1: S13-23).

(24)

There is limited available literature to evaluate the effectiveness of tonsillectomy for the treatment of dysphagia. A prospective cohort study of children undergoing tonsillectomy or adenotonsillectomy for dysphagia reported significantly improved quality of life scores related to swallowing after surgery as well as increased weight percentile for age (Clayburgh et al., Arch Otolaryngol Head Neck Surg 2011, 137: 1197-202). Recent guidelines support tonsillectomy for patients with dysphagia (Lescanne et al., Eur Ann Otorhinolaryngol Head Neck Dis 2012, 129: 264-71).

(25)

Tonsillectomy is indicated for children in whom there is a high clinical suspicion of malignancy (Lescanne et al., Eur Ann Otorhinolaryngol Head Neck Dis 2012, 129: 264-71). Non-Hodgkin lymphoma is the most common malignant head and neck tumor encountered in children and the palatine tonsils are the most frequent site of extra-nodal involvement. A recent systematic review of case studies found that the most common clinical findings of peritonsillar lymphoma were unilateral tonsillar enlargement or tonsillar asymmetry, visible lesion or color alteration of tonsil, cervical adenopathy, dysphagia, and snoring or sleep apnea. Additionally, it is important to consider the timing of the onset of symptoms (e.g., those that begin more suddenly have a higher likelihood of malignancy) and symptoms that occur in an immunocompromised child (Guimaraes et al., Crit Rev Oncol Hematol 2014, 90: 146-51).

(26)

Oral hygiene includes gargling and the use of a water irrigation device or an alternative method for throat cleansing.



ICD-9 (circle all that apply): 146.0, 146.1, 146.2, 277.31, 28.2, 327.23, 463, 474.00, 474.11, 474.8, 475, 784.44, 784.49, 786.09, 787.20, Other_____

CPT® (circle all that apply): 42825, 42826, 42870, Other_____