



# Carolina Ear, Nose & Throat Head and Neck Surgery Center

## Facts on Tonsillectomy

- In the United States, the number of tonsillectomies has actually declined significantly and progressively since the 1970s. The frequency with which tonsillectomy is performed varies from region to region. The variation appears to be related to differences in the medical practice of general practitioners, pediatricians, and otolaryngologists, in the management of recurrent tonsillitis and other conditions affecting the upper airway.
- 30 years ago, approximately 90% of tonsillectomies in children were done for recurrent infection; now it is about 20% for infection and 80% for obstructive sleep problems (OSA).
- The “gold standard” for the diagnosis and quantification of OSA is full-night polysomnography, or sleep study. However, polysomnography is expensive, time-consuming, and often unavailable. Consequently, most otolaryngologists will perform an adenotonsillectomy (T&A) based on a strong clinical history and parental observation in a child with chronically enlarged adenoids and tonsils.
- Extensive data shows the negative effects of OSA in children on behavior, school performance, and bed-wetting. Improvement for such behaviors following tonsillectomy is very well documented.
- Tonsillectomy for recurrent tonsillitis is effective at significantly reducing the number and severity of sore throats in children who are severely affected. There is also anecdotal evidence that some children’s quality of life is transformed by the surgery. This may be caused by a combination of factors that include the tendency of the frequency of recurrent sore throats to resolve over time and the elimination of a source of infection and of obstructive symptoms. These conclusions were published in “TO TREAT: Tonsillitis Outcomes – Toward Reaching Evidence in Adults and Tots,” a January 2008 supplement to the journal *Otolaryngology-Head and Neck Surgery*.
- Tonsillectomy alone is performed infrequently in children younger than 1 year old, whereas adenoidectomy alone is performed infrequently in individuals older than 14. The rate of adenoidectomy is about 1.5 times as high in boys as in girls, while the rate of tonsillectomy is almost twice as high in girls than in boys.
- On financial incentives favoring surgical intervention: Tonsillectomy

reimbursement ranges from approximately \$180-\$300 across all payers. For example: Medicaid reimbursement to the surgeon for performing the procedure within the state of Virginia is currently \$200, and this includes all the follow-up care for 90 days following the procedure. Some payers base their fee schedules on a percentage of the Medicare payment. Out of this payment, the physician must pay significant malpractice insurance costs, as well as overhead costs for the practice, including staff salaries and benefits, and utilities.

## References:

1. The average Medicare payment for 2009 (Federal Register, Vol. 73, No 224, Wednesday, November 19, 2008/Rules and Regulations. The 2009 Physician Reimbursement Conversion Factor = \$36.0666; Federal Register/page 697726) for Tonsillectomy & Adenoidectomy, under age 12 (Surgeon CPT Code = 42820) is \$270 and also includes 90 days of postoperative follow-up. Reimbursement for Tonsillectomy alone, under age 12 (Surgeon CPT Code = 42825) is \$242. In the commercial payer realm, the reimbursement varies, but is not markedly higher. With the pre-authorization requirements and 90-day all-included global periods typically associated with tonsillectomy, the procedure does not yield a much greater return for surgical versus medical management of a patient. The decision to perform a tonsillectomy should be based on a physician-patient partnered approach and evaluation of the patient's overall health status.
2. Derkay, CS. Pediatric otolaryngology procedures in the US: 1977-1987. *Int J Pediatr Otolaryngology* 1993;25:1-12.
3. Ross, AT, Kazahaya, K, Tom, LW. Revisiting outpatient tonsillectomy in young children. *Otolaryngol Head Neck Surg* 2003;128:326-31.
4. Bloor, MJ, Venters, GA, Samphier, ML. Geographical variation in the incidence of operations on the tonsils and adenoids: an epidemiological and sociological investigation. Part I. *J Laryngol Otol* 92:791, 1978.
5. Glover, JA. The incidence of tonsillectomy in school children. *International J Epidemiology* 2008; 37 (1): 9-19.
6. McPherson, K, Wennberg, JE, Hovind, OB, et al. Small-area variations in the use of common surgical procedures: an international comparison of New England,
7. Clinical indicators tonsillectomy, adenoidectomy, adenotonsillectomy. *Am Acad Otolaryngol Head Neck Surg*. <http://entnet.org/practice/products/indicators/tonsillectomy.html>. Accessed August 17, 2006.
8. TO TREAT (Tonsillitis Outcomes – Toward Reaching Evidence in Adults and Tots) *Otolaryngol Head Neck Surg* 2008; 138, S
9. Goldstein, N, Stewart, M, Hannley, M, et al. Quality of life after tonsillectomy in children with recurrent tonsillitis. *Otolaryngol Head Neck Surg* 2008; 138, S 9-S16