TITLE Myringotomy and Tympanostomy Tube Insertion Prior Authorization Guideline
RESPONSIBLE AREA Health Services
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DESCRIPTION

This guideline is used in the prior authorization and decision-making process regarding requests for myringotomy and placement of tympanostomy tubes.

DEFINITIONS

Myringotomy – incision of the tympanic membrane to allow ventilation of the middle ear, drainage of middle ear fluid, or to obtain cultures from an infected middle ear.

Tympanostomy Tubes – tubes which are placed within an incision made during myringotomy into the eardrum in order to keep the middle ear aerated for a prolonged period of time, and to prevent the accumulation of mucus in the middle ear.

Otitis media with effusion (OME) - presence of a middle ear effusion (MEE) without signs or symptoms of infection. This was previously called serous or secretory otitis media (SOM). OME that persists beyond 3 months often is called chronic otitis media or chronic otitis media with effusion.

Acute otitis media (AOM) – an infection of the middle ear with acute onset, presence of MEE and signs of middle ear inflammation. Treatment-failure of AOM is a lack of improvement in signs and symptoms within 48 to 72 hours after initiation of antibiotic therapy

Recurrent AOM – three (3) or more AOM episodes occurring in the previous 6 months or four or more AOM episodes in the preceding 12 months.

Chronic supportive otitis media (CSOM) – purulent otorrhea which is associated with a chronic perforation of the eardrum and active bacterial infection within the middle ear space which lasts for 6 weeks or more, despite appropriate treatment for AOM.

CLINICAL GUIDELINE

Clinical Considerations for OME:

- The AAP policy on OME recommends watchful waiting for 3 months after diagnosis because the harm of a persistent OME is slight when compared with possible harm from treatment

(antibiotic overuse and resistance). The child might experience a temporary hearing deficit while the effusion persists, but a short-lived effusion should have minimal effect on a child's language development.

- Children with persistent OME should be re-examined at 3 to 6 month intervals until the effusion is no longer present, significant hearing loss is identified, or structural abnormalities of the eardrum or middle ear are suspected.
- When OME persists beyond 3 months or there is moderate to severe hearing deficit, language delay, or developmental delays, the child's hearing should be evaluated. Children who are **not** identified by developmental surveillance or screening as being at risk are not likely to experience significant language delays from persistent OME. Short-term hearing loss and language delays may result from persistent effusions, but these conditions are likely to resolve without additional management in most children.
- As long as a low-risk child experiences minimal symptoms and shows no signs of hearing loss, OME can be observed without intervention. In ongoing studies, children with early tympanostomy tube placement (vs. delayed insertion) have not demonstrated any significant effect on developmental progress. [5]
- The current AAP guideline on OME, based on strong research evidence, suggests that children at risk for (or experiencing) developmental delays, experiencing symptoms secondary to the OME (otalgia, vestibular disturbance, hearing loss), or living in a non-enriching environment may benefit from intervention for a persistent OME.
- Candidates for surgery include children with OME lasting 4 months or longer with persistent hearing loss or structural damage to the tympanic membrane or middle ear.
- Adenoidectomy should not be performed unless a distinct indication exists (nasal obstruction, chronic adenoiditis).
- Repeat surgery should consist of adenoidectomy plus myringotomy, with or without tube insertion.

Tonsillectomy alone or myringotomy alone should not be used to treat OME:

- Clinicians should not perform tympanostomy tube insertion in children with recurrent acute otitis media (AOM) who do not have middle ear effusion in either ear at the time of assessment for tube candidacy.

Criteria to Substantiate Medical Necessity for Myringotomy and Tympanostomy Tube Placement:

- Recurrent acute otitis media (AOM) – 3 distinct episodes of acute otitis media within 6 months or 4 or more distinct episodes within 1 year.
  - Documented evaluation and appropriate treatment
    - Appropriate treatment is defined as use of first or second line antimicrobial agents (Amoxicillin, high-dose Amoxicillin, Amoxicillin/clavulanic acid, Cefdinir) for an appropriate length of time (7 -10 days).
- Documented otitis media with effusion (OME) lasting 3 months or longer with:
  - Documented hearing loss, or
  - Physical abnormality of the tympanic membrane or middle ear structures, or

- Recurrent or persistent AOM (as defined above) of the same ear, or
- Significant otalgia requiring multiple PCP or ED visits.

- Other Considerations:
  - Complications of otitis media
  - Meningitis
  - Facial nerve palsy
  - Mastoiditis
  - Brain abscess
  - Retraction pockets
  - Previous history of Myringotomy tube placement
  - Cholesteatoma

PLEASE NOTE: State and Federal law take precedence over prior authorization guidelines. CMDP reserves the right to review and update guidelines periodically.

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