Ready to Make a Difference This Spring? Join Us in Washington, DC p22

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Home Is Where the Votes Are:

American Academy of Otolaryng

April 2013-Vol.32 No.04

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THE REPORT OF THE REPORT OF

24

30

22

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CMS Quality Reporting Initiatives Fact Sheets page 34

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- 24 Home Is Where the Votes Are: In-District Grassroots Outreach (I-GO)
- 26 Overview: 2013 Federal Legislative Priorities

Ad Index

Officite	IFC
Sanofi	01
Olympus	02
BFW	05
Arches Natural	06
Doc's Proplugs	08

The Doctors Company	12
Invotec	14
Meda Pharma	18
Teva	28
Doc's Proplugs	29
McKeon	ВС

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aao-hns/f news

- 07 Face to Face Patient Care
- 09 Advocacy Is a Team Sport
- 10 What Is the BOG and What Can It Do for Me?
- 11 In Memoriam: Charles J. Krause, MD, Past AAO-HNS/F President
- **13** Academy Advantage Partner EYEMAGINATIONS: Why Patient Education Is Important
- 13 ENTLINK App: The Best Way for Patients to Find You
- **14** Academy Advantage Premier Partner The Doctors Company: Best Practices for Creating an ACO
- 15 Lunch and Learn to be Social: A Media and Public Relations Event
- 16 International Historical Society's Meeting in Padua
- 16 OHS Call for Papers
- 17 If History Still Lives for You, Attend Our Otolaryngology **History Society Meeting**
- ONLINE Mark Your Calendar: May Is Better Hearing and Speech Month; Dates to Remember at www.entnet.org/bulletin

22 feature: grassroots & legislative advocacy

- 22 Ready to Make a Difference This Spring? Join Us in Washington, DC
- 24 Home Is Where the Votes Are: In-District Grassroots Outreach (I-GO)
- 25 Alphabet Soup: Acronyms Advocates Need to Know
- 26 Overview: 2013 Federal Legislative Priorities
- 27 Overview: 2013 State Legislative Priorities
- 30 Fighting an Antiquated Law: Hearing Aid **Dispensing in New York**

31 regulatory advocacy & business of medicine

- 31 3P Update: EHR Cloning and Provider Responsibility
- 34 CMS Quality Reporting Initiatives Fact Sheets
- 36 Fact Sheets on CMS Quality Initiatives
- 37 Medicare Quality Penalties: A Wizard Can Help
- 39 Coding and Reimbursement Strategies: Using an Unlisted Code for Endoscopic Skull Base Surgery
- 40 Sample Prior Authorization Letter for Unlisted CPT Code on Endoscopic Skull Base Surgery
- 41 CPT Code Changes: Implantation of Biologic Implant +15777

42 education

4

- 42 Professional Development Gap Analysis and Needs Assessment Initiative Under Way
- 44 Experience Vancouver, BC, Canada
- 45 Travel to Canada

our community

- 47 4th International Coalition for Global Hearing Health Conference Set
- 47 Last Chance to Book for Dr. K.J. Lee's 2013 China Tour

bulletin

April 2013 | Vol.32 No.04

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Face to Face Patient Care

y friends, with six months of my presidential year behind me now, I can really say, as time goes by, it goes by more quickly. So, I feel some urgency to make the most of each chance given me to further our Academy strategy this year. Therefore, on May 5 and continuing through May 7, I hope to join some of you in Washington, DC, to advocate personally for quality patient centered otolaryngic care.

With each new Congress, we have the opportunity to advance the targeted

legislative issues your Board and other AAO-HNS/F leaders have picked as those where our advocacy can best exercise influence for the good of our patients' care. The road maps for these efforts, our federal and state issue platforms, are outlined on pages 26 and 27 in this issue.

To prepare you for your Capitol Hill visits and this opportunity, our own BOG member-volunteers connect with issue experts to present practical workshops and "backgrounders" that will help us carry the specialty messages to our elected leaders. One of these events, and

the most exciting for me, will be the BOG-hosted Presidential Forum that allows our president-elect candidates to address attendees directly on those questions outlined for them by our excellent Nominating Committee.

The Hill Visits

These member-to-member meetings lead up to the face-to-face meetings with legislators and congressional staff that present the best chance we each have to influence history—the moment each of us can personalize what patient care should be. In these sometimes small yet important offices, our legislators can clearly see in each of us how much we care about our patients. You will be the face of otolaryngologic care for each person you talk to that day.

Face to Face with Patients

Doctor, Please Explain

Eardrum

What is a perforated eardrum?

What causes eardrum perforation?

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and more..

How is hearing affected by a perforated eardrum?

Perforated

More often than ever the issues we will discuss with these legislators and among ourselves at home involve the integration of care—diagnosis and treatment, outcomes and performance, safety and quality, knowledge and transparency—all of a piece. This coming together of

> disciplines is changing how we practice medicine. For instance, we often mention the importance of guideline development and a guideline's "translation to practice" as steps to that integration. When guidelines are introduced, it is the optimal time to think not just of how we will incorporate these new recommendations into our care, but also how we will make new recommendations available to patients.

Keeping patients engaged in healthcare decisions is part of what we must do now more than ever when costs are so high and options for care more confusing. To encourage

these conversations, last month this organization announced its list of five procedures that physicians and patients should discuss to assess quality care and safety in treatment options. These conversations will involve data and decision-making in a way that is focused and involving for both patients and physicians.

Informational materials that can be made available to patients to revisit will be more helpful than ever to the process. In a blog post on the ABIM Foundation *Choosing Wisely®* website, Executive Vice President Daniel Wolfson, MHSA, wished (from his own patient experience) for the following physician/patient



James L. Netterville, MD

James L. Netterville, MD AAO-HNS/F President

competencies: "Provide me with the clinical evidence about the options for surgery, professional opinions on the best course for my situation, and help me to make the best decision for myself. . . As a patient I want to feel we are in conversation about my health and that he [the physician] is fully present with me."

Our clinical committees are working harder than ever to update the Academy patient information materials in concert with guideline development, product relevancy efforts, and such initiatives as those of the *Choosing Wisely®* campaign. Join me then in May to personalize care. Come to DC to see your legislators, and at home, take advantage of the tools available like those for Better Hearing and Speech month to help your patients to talk about options. Use the "bonus" patient information leaflet in this *Bulletin* to help (and see page 46).

For more special community outreach materials, login to www.entnet.org/ Community/outreach.cfm.

Source:

The "Other" Physician and Patient Competencies—What's all the Fuss?; Daniel Wolfson, September 4, 2012. Accessed from http://blog.abimfoundation. org/the-%e2%80%9cother%e2%80%9dphysician-and-patient-competencies%e2%80%94what%e2%80%99s-all-thefuss.



Advocacy Is a Team Sport

hile advocacy is always a prominent topic in the Bulletin, this month has additional focus on the efforts the Academy makes on behalf of its members, and by extension, their patients. You have recently read much about how the elected and appointed leaders of the Academy have successfully intervened, contributed to, and positively influenced healthcare policy on our behalf-sometimes in concert with other societies with shared issues, and sometimes specifically and exclusively regarding otolaryngology. Examples of the former include our comments on the Patient Protection and Sunshine Act (PPSA); support of the Council of Medical Specialty Societies' "Code for Interactions with Companies;" or our many comment letters on proposed rules for a host of elements of healthcare reform legislation. The latter category is illustrated by our response to the FDA on the issue of blackbox warnings for the use of codeine for pain relief in children post-tonsillectomy; our participation in the Choosing Wisely® campaign; and our World Voice Day activities, among many others.

How This Happens

We have just completed the update of strategies, actions, and work plans for the next 12 to 18 months of Academy and Foundation initiatives and the extensive review and approval of our boards of directors, executive committees, finance and investment sub-committee (FISC), and our budgeting process.

The manner in which the extensive scope of Academy activity is identified, prioritized, developed, and implemented is complex, but very effective. Considering our budget and resources, I believe we "accomplish more with less" than just about any other major medical society, in large part because of the tremendous spirit of volunteerism and the culture of contributing to the profession that characterizes otolaryngology-head and neck surgery. On many levels the Academy's structure and governance requires teamwork and collaboration, mentoring and development, and the leveraging of assets to accomplish so much. While some of this is cultural and consistent with the personal attitudes and behaviors of our members and staff, a great deal occurs intentionally through training and skill-building of staff, management, board, and membership.

Each year the Executive Leadership Team (ELT) of the Academy/Foundation engages in ongoing leadership and skills training to expand our abilities. Part of this year's training included a discussion on "high performing teams" and taking action on specific elements of improvement. After a review of the expansive literature and the publications of the many experts on teamwork, we culled and focused on a collection of principles that we believe embody the most essential elements of highly functioning teams. We combined these principles into four categories: 1) superior communications and related learning environment; 2) alignment around a common purpose and supported leadership; 3) effective planning and work processes that lead to measurable solutions; and 4) a foundation of trusting relationships and environment.

- **Communications:** After several years of staff surveys with successful actions to address needed change, we note that "communications" always seems to be an issue raised in an organization committed to improvement. It is our experience that the need for improved communications is either a significant part of any problem, or a key to the solution.
- Alignment: Alignment is highly related to communications. We believe that the single most important element necessary for success is clarity and a compelling vision around a specific purpose or goal. The ability of all members of a team to articulate the desired outcome and to champion the cause is directly related to the degree of success of the team. The more team members there are who just "go with the flow," the greater the likelihood of failure or stagnation.
- Effective processes: Processes include the identifying, prioritizing, and



David R. Yulun MD

David R. Nielsen, MD AAO-HNS/F EVP/CEO

planning processes; as well as the work flow processes and measures of completion. There has to be a balance between those team members who excel at the planning and envisioning of the results and the pragmatic and realistic workers who implement and carry out the actions. People are rarely great at both, and mutual respect for the absolute necessity of each focus is essential.

Trust: An environment of trust is built both on competence and character. While it is tempting to believe that trust is based only on honesty and integrity, being "able" is the key to being "accountable." Failing to deliver on an agreed upon expectation can undermine trust as rapidly as being disingenuous or insincere. In fact, part of being truly honest requires us to accurately assess what we can accomplish and then to make good on our commitments.

Your elected leaders and all the professional staff here in Alexandria, VA, and Washington, DC, commit to continuously improving our teamwork as we advocate with you to empower us to provide the best possible patient care.

What Is the BOG and What Can It Do for Me?

Sujana S. Chandrasekhar, MD Immediate Past Chair, BOG

his is the 31st year of the Board of Governors (BOG), but many of the 12,000-plus members of our Academy don't understand what it is, what it does, or how they can interact with it and benefit from it. So, here's a primer.

WHO: The Board of Governors represents each member of the AAO-HNS. Its mission is to function as the representative of member otolaryngologists' grassroots and socioeconomic concerns, and to bring those concerns to the Board of Directors (BOD) of the Academy. As such, the interface between the BOG and Academy activities occurs at committee meetings and in the development of educational offerings; at task forces (TF) such as the Guidelines Task Force and TFs that select coordinators and journal editors for the Academy; and directly at the Executive Committee (EC) and BOD of the Academy.

HOW: Your concerns are represented at the BOG. There are local, state, regional, and/or national and international ENT society members of the BOG. These include the state otolaryngology societies, the national subspecialty societies, and either region-based or subspecialty-based societies. There are currently more than 60 local/state/regional societies, 17 national societies, two sections, two committees, and 54 International Corresponding Societies (ISC) that belong to the BOG.

Each member society has three representatives to the BOG. There is a governor, a legislative representative, and a public relations representative. These individuals are appointed by their societies, and are expected to attend the BOG Spring Meeting in Alexandria, VA, the Fall BOG meeting the Saturday before the start of the Annual Meeting & OTO EXPO, and the BOG General Assembly (GA) the Monday afternoon of the annual meeting. All Academy members are welcome to attend the GA, but only a member society's governor may vote. If the governor cannot attend the GA, then one of the other two representatives may vote.

WHAT: The structure of the BOG is as follows. Every year, there is a new chair-elect, who is elected at the Fall GA meeting. Every other year, there is a new secretary and a new member-at-large, whose elections are staggered, and who serve two-year terms. Their candidate statements are published in the Bulletin, and you can get to know them at the BOG Spring Meeting and during committee meetings. There are three major BOG committees: the Legislative Representatives Committee; the Socioeconomic and Grassroots Committee; and the Rules and Regulations Committee. Any member of the Academy in good standing can apply for membership to any of these committees through the normal Academy committee process, which ends every February. There is also a Nominating Committee, chaired by the immediate past chair of the BOG (me, this year) and has members elected at the GA. When needed, BOG task forces with a shorter shelf life are created. An example of a successful TF was the BOG Development TF, which helped launch the Millennium Society and has been folded into the Foundation's Development Committee. The Executive Committee of the BOG consists of the chair, chair-elect, immediate past chair, secretary, member-at-large, and committee chairs and vice chairs.

The BOG Executive Committee meets regularly to deliberate on matters of importance to practicing otolaryngologists in all types of work environments. We are an excellent first-line access point for practice and legislative matters that need to get to the attention of the Academy leadership and staff. The chair and chair-elect of the BOG sit on the Academy's Executive Committee, with the chair having a voting position. The chair, chair-elect, and immediate past chair are all voting members of the Academy's BOD. There is BOG representation on all Academy taskforces.

WHEN: Plan to attend the BOG Spring Meeting & OTO Advocacy Summit May



Sujana S. Chandrasekhar, MD

5-7, 2013, in Alexandria, VA, and plan to storm Capitol Hill and meet with your legislators on May 7. This is a free member benefit open to all Academy members, and it is a lot of fun. Please try to bring a resident or two with you so they can be mentored as well.

Arrive in Vancouver a day early this year and attend the BOG committee meetings on Saturday, September 28, 2013. You will love the camaraderie, the give-and-take, and the opportunity to make your perspective heard. Monday, September 30, plan to attend the BOG General Assembly beginning at 5 pm. Encourage your society's representatives to attend and vote. Also be sure to attend the BOG-sponsored miniseminar, "Hot Topics in ENT." You'll be amazed at what you'll learn about your own practice.

WHY: The BOG is a remarkable group within our Academy that offers every otolaryngologist an opportunity to have his or her voice heard. It is a wonderful place to learn more about the practice and legislative aspects of ENT, and to learn and build your own leadership skills. As the healthcare landscape changes, we can't keep our heads buried in the sand or hidden in the ivory tower. It is up to us, the otolaryngologists, to guide our citizens and legislators on the right path, and the BOG affords us that ability.

You can always reach the BOG at bog@ entnet.org, or contact any of us on the Executive Committee directly. I look forward to seeing you at future BOG events.

In Memoriam: Charles J. Krause, MD, Past AAO-HNS/F President

harles J. (Chuck) Krause, MD, who served as AAO-HNS/F president from 1996 to 1997, died on February 7, in Naples, FL. Dr. Krause was the former chair of the department of otolaryngologyhead and neck surgery at the University of Michigan.

Academy President **James L. Netterville, MD**, said upon hearing the news, "It was with heartfelt sadness and a sense of professional loss that I note the death of one of the specialty's most dedicated leaders—that of Charles Krause, MD."

During his career, Dr. Krause also served as president of the American Society of Head and Neck Surgery, the American Board of Otolaryngology, and the American Academy of Facial Plastic and Reconstructive Surgery.

Originally from Iowa, Dr. Krause earned both his BA (1959) and his MD (1962) degrees from what was then known as the State University of Iowa, now known as the University of Iowa. He interned at Philadelphia General Hospital from 1962 to 1963, and served at the USAF Hospital at Randolph Air Force Base from 1963 to 1965. He returned to the University of Iowa and undertook residency training there from 1965 to 1969. From 1969 to 1977, Dr. Krause served as a faculty member in the department of otolaryngology and maxillofacial surgery at the University of Iowa.

In 1977, Dr. Krause was recruited to join the faculty at the University of Michigan as a professor of otolaryngology and served as chair of the department until 1992. He served in leadership positions in various hospitals and health centers in the Michigan area, including dean for clinical affairs at the medical school and chief of clinical affairs at the University of Michigan Hospitals. He was appointed senior associate dean for clinical affairs at the medical school in 1992. He served as senior associate hospital director for medical affairs from 1995 to 1996 and returned to clinical practice in the department of otolaryngology in 1996. He remained active on the faculty until 2000.

Dr. Krause served with distinction as a clinician, faculty member, senior hospital administrator, and as a world-renowned speaker.

In addition to his clinical work, he was extremely active in the humanitarian outreach. Prior to his retirement, he established the Barbara and Charles Krause Lectureship in Humanities in Medicine in the department of otolaryngology-head and neck surgery at the University of Michigan Medical School. In recognition for his support and contributions to the promotion of cultural diversity with his establishment of the first departmental diversity committee, he was awarded the Harold R. Johnson Diversity Service Award in 1999. In November 2012, he and his wife Barbara attended the first installation of the Charles J. Krause, MD, Collegiate Professorship in Otolaryngology, an honor given to Carol Bradford, MD, chair of otolaryngology.

David R. Nielsen, MD, Academy EVP/ CEO, remembered Dr. Krause as a wonderful role model, "Dr. Krause had the rare quality of inspiring immediate confidence from everyone who met him. He seemed like a mentor and friend even to those who knew him only moderately well. I was certainly the beneficiary of his kind compliments and counsel on many occasions. His positive influence will continue in the next generation of leaders."

Neil O. Ward, MD, MALS, then AAO-HNSF President, remembers, Chuck Krause served as the Academy's president-elect during the AAO-HNS 1996 Centennial Year. "It was my pleasure to get to know him well during that year," he said, "and subsequently he and I shared the privilege of offering the membership a dues reduction during our tenure."

Dr. Krause's AAO-HNS presidential term began in September 1996 at the annual meeting in Washington, DC, when the Academy was celebrating its centennial year. In addition to his term as president, his service to the AAO-HNS included many leadership positions. During the late 1980s, he served on the Building Committee, which had oversight



Charles J. (Chuck) Krause, MD

of the AAO-HNS purchase of the new Academy headquarters building at One Prince Street. He chaired several committees, including the Ethics Committee, the Nominating Committee, the Bylaws Committee, and the Humanitarian Efforts Committee. He served on the Editorial Board of the journal and was active on several committees throughout his involvement with the Academy. In 2003, he received both an Honor Award and the Distinguished Service Award.

Dr. Krause is survived by his beloved wife of 50 years, Barbara, his daughters Sharon and Ann, and his son John, and their families. The former AAO-HNS Executive Vice President. Jerome C. Goldstein, MD, greatly valued his association with Dr. Krause, "Chuck Krause and I were friends for more than 30 years... I was president of Council of Medical Specialty Societies in 1995 and he was the Academy delegate to that organization, and I counted on his support. He was president of the Academy in 1987, and I was senior EVP so we had a chance to work together again. Chuck's management style was to lead by building consensus. He brought different people together who had ideas that could be disruptive and by fostering discussions led them through compromise. . . He was a master at this. Chuck was a calm and thoughtful visionary and contributed much to our specialty."

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Academy Advantage Partner EYEMAGINATIONS: Why Patient Education Is Important

ccording to a recent University of Minnesota study, patients retain only 50 percent of the information provided by healthcare providers, with half of that information recalled incorrectly.¹ So why might this breakdown in communication exist? Well, it could be inconsistent patient education.

When considering implementation of a formal patient education program, here are a few thoughts to consider:

Do Your Patients Fully Understand Their Conditions and Prescribed Treatment Options?

The better you can educate a patient, the more they will trust you and make the best decisions about their medical care. Simply, better-educated patients make better decisions, therefore ensuring that your existing client base keeps coming back for follow-up visits.

Is Your Patient Education Messaging Consistent across All Staff Levels?

Streamlining your patient education program ensures that the same information is received no matter whom patients speak to in your practice. This makes

EYEMAGINATIONS

educating patients the responsibility of your entire staff, saving you valuable time in the exam room.

Does Your Website Match Your Practice Messaging?

A recent Pew Internet Project report indicated that 80 percent of all Internet users look online for health information specifically.² The way that you are represented online should always be consistent with how you are represented during an office visit.

In summary, a dedicated patient education program can save you time and reinforce what your patients learn during the office visit. Eyemaginations helps to improve patient understanding and informational recall through a suite of tools to help practices simplify complex topics and reinforce clinical messaging.

Here are a few ways that better patient information can help:

Increase conversion rates by educating patients in the waiting room on your offerings.

Pod :

- Save 10 minutes of your time per patient by showing condition development and point-of-view perspectives quickly and efficiently to patients in the exam room via iPad or PC.
- Increase traffic and improve patient retention by integrating animations onto your website to reinforce messaging, so patients can review your recommendations at any time.

As an AAO-HNS Advantage Partner, Eyemaginations remains committed to helping you achieve your patient education goals. For more information, we invite you to call us directly at 1-877-321-5481, email entinfo@eyemaginations.com, or visit us online at www.eyemaginations.com.

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ENTLINK App: The Best Way for Patients to Find You

One of the most visited online Academy sites, "Find an ENT," is now available as a mobile app, ENTLINK! This app helps patients locate an ENT quickly and easily, and allows you to find colleagues in order to refer patients. You can search by location, proximity, name, and subspecialty. All AAO-HNS members are automatically included in the Academy's online directory. Be sure to update your AAO-HNS profile at **www. entnet.org/profile** or, email memberservices@ entnet.org, so colleagues and patients can find you quickly. The ENTLINK App is free and available for download in iTunes and Android stores.

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Academy Advantage Premier Partner The Doctors Company: Best Practices for Creating an ACO

he U.S. healthcare system is moving toward Accountable Care Organizations (ACOs), groups of healthcare providers who agree to be accountable for the quality, cost, and overall care of Medicare patients. According to the Future of Health Care Survey conducted by The Doctors Company, the nation's largest medical malpractice insurer, 57 percent of doctors are either undecided or need more information on ACO participation.

In the YouTube video, *Principles for ACO Success: Health Care and Clinical Integration*, found at www.youtube.com/ doctorscompany, healthcare industry thought leaders recommend the following best practices when forming ACOs:

1. Create a readiness checklist.

"A readiness checklist...involves things like patient-centered medical homes and the attributes that primary care physicians have," said Robert J. Jackson, MD, MMM, president and medical director, Accountable Healthcare Alliance in Michigan. "It talks about, 'How well do we deal with data? Do we have patient registries? Do we have patient care plans? Do we have transition of care issues developed?""

2. Meet patients' specific needs.

"The key is designing the care management tools, resources, people, and interventions to manage the specific needs of that patient," said Laura P. Jacobs, MPH, executive vice president, The Camden Group in California.

3. Develop clinical integration.

"Make sure all the providers are engaged in real-time information sharing so a care plan can be developed within a very quick period of time and all the providers know their roles and the timelines in which they have to perform their services," said Michael H. James, JD, president and CEO of Genesys PHO, a pioneer ACO, and Genesys Integrated Group Practice in Michigan.

4. Engage the community.

"The community has to...support programs that improve health and improve the way patients live because healthcare goes beyond just acute care," James said. "It involves the patients' safety, whether they have enough to eat, their transportation, education, business opportunities or employment opportunities."

5. Select the right board members.

"A pioneer ACO requirement is to expand the board with a patient and a community advocate," James said. "Genesys...selected the leader of their volunteer group. He is 72 years old and is very engaged and involved in community studies on how to improve access to care. The community advocate is the executive director of a group of nursing homes."

Contributed by The Doctors Company. For more risk tips, patient safety tips, and physician practice tips, visit www. thedoctors.com.



14

Lunch and Learn to be Social: A Media and **Public Relations Event**

Wendy B. Stern, MD, BOG Secretary Chair, Media and Public Relations Committee

hat is more social than a social media luncheon? The BOG has invited the Academy's Media and Public Relations Committee to present a discussion on various aspects of social media in the academic and private practice settings. This luncheon will take place on Sunday, May 5, as part of the BOG Spring Meeting & OTO Advocacy Summit. The knowledgeable luncheon speakers are sure to generate interest and discussion.

Spencer C. Payne, MD, is an associate professor and director of rhinology at the University of Virginia, department of otolaryngology. Familiar with technology and creating an online presence since the early 1990s, he has helped bring his department to social media using the basics



of Facebook and Twitter within university policy. He will discuss the basics of social media, establishing a presence, and taking steps to prevent unnecessary medico-legal exposure and risk as they apply to the academic physician.

Christopher Y. Chang, MD, is a solo private practice otolaryngologist in northern Virginia who has been active in social media since 2005. Being an early adopter, he has throughout the years developed techniques of effectively using social media to develop one's practice while simultaneously being time efficient in this important marketing activity.

Although he is in solo private practice and lacks brand-name recognition, he has successfully developed a well-recognized social media and Internet presence with thousands of followers and hundreds of millions of views. For this presentation, he will convey tips and strategies that others can incorporate when developing their own social media presence not only effectively, but also efficiently when considering how precious time has become.

The BOG is committed to providing a variety of lectures that will enhance your practice of otolaryngology. Please join us. 🗖



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International Historical Society's Meeting in Padua

Robert J. Ruben, MD

ast August, the International Society of the History of Otolaryngology conducted its sixth working meeting in the historic medical school of Padua University, 20 miles west of Venice, Italy. The host was Alessandro Martini, MD.

The wide-ranging program attended by 30 participants included historical aspects of anatomy, research, global hearing health, and giants in the specialty, with speakers from Canada, Germany, Italy, Switzerland, the United Kingdom, and United States. It addressed such famous historical figures as Kaiser Frederick III, the composer Giacomo Puccini, and the discoverer of ancient Troy, Heinrich Schliemann.

The meeting opened with a tribute to our departed colleague, Dafydd "Dai" Stephens, PhD, professor of audiological medicine, Sussex University, UK.

The meeting continued with the following presentations:

- Bonaventura Angeli and His Description of Ménière's Symptoms in "De Vertigine et Scotomia," by Alessandro Martini, et al;
- Symbols of Medicine in the Seal of the Padua Medical School, by Giorgio Zanchin;
- Historico-medical Research in Otology: Pitfalls, Doubts, and Successes, by Albert Mudry and Wolfgang Pirsig;
- Who First Described and Depicted the Foramen in the Anterior External Bony Auditory Meatus, Mostly Termed Foramen of Huschke?, by Wolfgang Pirsig and Albert Mudry;
- Three Knights of King's—Sir Victor Negus, by Neil Weir;
- Analysis of a Letter from Felix Semon to Count Herbert von Bismarck, Secretary of State of Prussia, Concerning Frederick III of Prussia, Dated July 12, 1888, by Robert J. Ruben and Wolfgang Pirsig;

- Forty to 300 Million with Disabling Hearing Loss, 1985-2005: How the WHO Changed its Mind, by Peter W. Alberti;
- A Brief History of Mastoidectomy and the Role of Hermann Schwartze, by Stefan K. Plontke, et al;
- The Last Journey of Heinrich Schliemann, by R. Ragona Marchese, I. Mylionakis, and Alessandro Martini;
- Role to Define: Medicine and Deafness in Nineteenth-century France, by Sabine Arnaud;
- The Unfinished *Turandot* and Puccini's Laryngeal Cancer, by R. Ragona Marchese and Alessandro Martini:
- Wenzel Leopold Gruber and His Ligament at an Anthropological Edge, by Herwig Swoboda; and

 Liaisons Heureuses—Medicine Between Padua, Trieste, and Vienna, by Herwig Swoboda.

In addition to this fascinating and thought-provoking program, we visited Padua's Anatomical Theater, established by the pioneering anatomist Girolamo ab Aquapendente; the Hortus Simplicius, the first botanical garden devoted to the teaching and study of plants of medical interest; and the Museum of the History of Medicine and Health (Museo di Storia della Medicina e della Salute).

The society's next meeting will be in Vienna, Austria, September 13-14. To learn more, email Albert Mudry at albert@oreillemudry.ch, or Wolfgang Pirsig at wolfgang.pirsig@extern.uniulm.de or museum@entnet.org.



(left to right); Peter W. Alberti, MD (AAO-HNS), Alessandro Martini, MD (conference host), Robert J. Ruben, MD (AAO-HNS), Albert Mudry, MD (Switzerland), guest, Neil Weir, FRCS (UK), guest, Wolfgang Pirsig, MD (Germany), guest, Mrs. Sue Weir (UK), and Mrs. Elizabeth Alberti (Canada)

OHS Call for Papers

Otolaryngology Historical Society Call for Papers: If you are interested in presenting at the next OHS meeting September 30, in Vancouver, BC, Canada, email museum@entnet.org.

To join the society or renew your membership, please check the box on your Academy dues invoice or email Catherine R. Lincoln, CAE, MA (Oxon) clincoln@entnet.org or call 1-703-535-3738.

If History Still Lives for You, Attend Our Otolaryngology Historical Society Meeting

Marc D. Eisen, MD, PhD

he Otolaryngology Historical Society (OHS) provides a forum for the discussion, presentation, and preservation of the history of all aspects of otolaryngology. The society welcomes otolaryngologists from around the world and from all stages of training and practice, as well as individuals in related fields.

OHS Annual Meeting

To keep life easy, we conduct our annual event in conjunction with the AAO-HNSF Annual Meeting & OTO EXPOSM. This event offers an informal social gathering for all members, guests, and those interested in medical history. There is no shortage of conversation, owing to the rich nature of this area and how history literally lives in our daily practice.

The program format includes select presentations on historical topics. Recent topics presented included the history of cochlear implantation, tonsillectomy, and the Eustachian tube; contributions of Avicenna, Julius Lempert, and Max Brödel; and otolaryngology in Byzantium. As you can see from the list, our range of interest is vast.

Submit an Abstract

The society strongly encourages submitting a history-related otolaryngology abstract as a possible presentation for the OHS meeting. Abstracts should be no longer than 300 words. Presentations are 20 minutes long, which includes five minutes for a lively exchange of questions and comments.

The Society's review panel will select the best abstracts for presentation based on originality, applicability, and historical content. As an incentive to join the society, preference will This event offers an informal social gathering for all members, guests, and those interested in medical history. There is no shortage of conversation owing to the rich nature of this area and how history literally lives in our daily practice. be given to those OHS members who submit abstracts.

Joining the OHS Is Easy

To join the OHS as a member or renew your OHS dues, check the box on your member dues invoice or email memberservices@entnet.org. Annual dues are \$50, which includes the OHS annual meeting and reception.

To learn more about the OHS or send an abstract, email Catherine R. Lincoln, CAE, MA (Oxon), staff liaison, History and Archives Committee, at museum@entnet.org or call 1-703-535-3738.



Dr. Marc Eisen, OHS president, at the 2012 meeting, Cosmos Club, Washington, DC.



for rapid and

Indication

Dymista Nasal Spray, containing an H_1 -receptor antagonist and a corticosteroid, is indicated for the relief of symptoms of seasonal allergic rhinitis in patients 12 years of age and older who require treatment with both azelastine hydrochloride and fluticasone propionate for symptomatic relief.

Important Risk Information

- Patients may experience somnolence. Caution patients against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery
- Patients should avoid concurrent use of alcohol or other central nervous system (CNS) depressants because additional reductions in alertness and additional impairment of CNS performance may occur
- Because of the inhibitory effect of corticosteroids on wound healing, avoid use in patients with recent nasal ulcers, nasal surgery, or nasal trauma until healed
- Glaucoma, cataracts, and increased intraocular pressure may be associated with nasal corticosteroid use; therefore, close monitoring is warranted in patients with a change in vision and/or with a history of increased intraocular pressure, glaucoma, and/or cataracts
- Patients using corticosteroids may be susceptible to infections and may experience a more serious or even fatal course of chicken pox or measles. Dymista should be used with caution in patients with active or quiescent tuberculosis; fungal, bacterial, viral, or parasitic infections; or ocular herpes simplex

- Systemic corticosteroid effects, such as hypercorticism and adrenal suppression, may occur with very high dosages or at the regular dosage in susceptible individuals. If such changes occur, discontinue Dymista gradually, under medical supervision
- Potent inhibitors of cytochrome P450 (CYP) 3A4 may increase blood levels of fluticasone propionate
- Ritonavir: coadministration is not recommended
- Other potent CYP3A4 inhibitors, such as ketoconazole: use caution with coadministration
- Intranasal corticosteroids may cause a reduction in growth velocity when administered to pediatric patients. Monitor the growth routinely of pediatric patients receiving Dymista
- In clinical trials, the most common adverse reactions that occurred with Dymista Nasal Spray, azelastine hydrochloride nasal spray, fluticasone nasal spray, and vehicle placebo groups, respectively, were dysgeusia (4%, 5%, 1%, <1%), epistaxis (2% for each group), and headache (2%, 2%, 2%, and 1%)
- Pregnancy Category C: based on animal data; may cause fetal harm



more complete relief from seasonal allergy symptoms



Magnitude of Nasal Symptom Relief Relative to azelastine HCl and to fluticasone propionate*¹²



Data shown are from study MP 4004. Across the 3 pivotal clinical trials, the improvement with Dymista ranged from 40% to 67% greater relative to the improvement achieved with either comparator.¹²

*As listed in the Full Prescribing Information, in 3 pivotal trials, symptom relief was measured by change from baseline in Total Nasal Symptom Score (TNSS) averaged over the 14-day study period. Dymista provided a statistically significant improvement in TNSS compared with both azelastine hydrochloride (HCI) and fluticasone propionate. The azelastine HCI and fluticasone propionate comparators used the same device and vehicle as Dymista and are not commercially marketed. Additionally, Dymista provided a statistically significant, rapid improvement in TNSS as early as 30 minutes after administration when compared with placebo.¹

**Data shown are from study MP 4004. Onset of action was defined as the first timepoint at which Dymista was statistically superior to placebo in the mean change from baseline in instantaneous TNSS and was sustained thereafter.¹

[†]Change from baseline in instantaneous TNSS following administration.²

[‡]Percent difference represents the improvement in TNSS with Dymista relative to azelastine HCl or fluticasone propionate comparator.²

[§]Change from baseline in the placebo-subtracted mean TNSS for each day (maximum score 24), averaged over the 14-day study period.²

References: 1. Dymista [package insert]. Somerset, NJ: Meda Pharmaceuticals Inc; 2012. **2.** Data on File. Meda Pharmaceuticals Inc. *DYNISTA*[™] (azelastine hydrochloride and fluticasone propionate) Nasal Spray 137 mcg / 50 mcg per Spray

Please see Brief Summary of Full Prescribing Information on the following pages.

www.Dymista.com

DYMISTA (AZELASTINE HYDROCHLORIDE 137 MCG / Fluticasone propionate 50 MCG) Nasal Spray

Brief Summary (for Full Prescribing Information, see package insert)

1 INDICATIONS AND USAGE

Dymista Nasal Spray is indicated for the relief of symptoms of seasonal allergic rhinitis in patients 12 years of age and older who require treatment with both azelastine hydrochloride and fluticasone propionate for symptomatic relief.

5 WARNINGS AND PRECAUTIONS

5.1 Somnolence

In clinical trials, the occurrence of somnolence has been reported in some patients (6 of 853 patients) taking Dymista Nasal Spray [*see Adverse Reactions (6.1*]]. Patients should be cautioned against engaging in hazardous occupations requiring complete mental alertness and motor coordination such as operating machinery or driving a motor vehicle after administration of Dymista Nasal Spray. Concurrent use of Dymista Nasal Spray with alcohol or other central nervous system depressants should be avoided because additional reductions in alertness and additional impairment of central nervous system performance may occur [*see Drug Interactions (7.1*]].

5.2 Local Nasal Effects

In clinical trials of 2 to 52 weeks' duration, epistaxis was observed more frequently in patients 38 treated with Dymista Nasal Spray than those who received placebo [*see Adverse Reactions* [6]].

Instances of nasal ulceration and nasal septal perforation have been reported in patients following the intranasal application of corticosteroids. There were no instances of nasal ulceration or nasal septal perforation observed in clinical trials with Dymista Nasal Spray. Because of the inhibitory effect of corticosteroids on wound healing, patients who have experienced recent nasal ulcers, nasal surgery, or nasal trauma should not use Dymista Nasal Spray until healing has occurred. In clinical trials with fluticasone propionate administered intranasally, the development of localized infections of the nose and pharynx with *Candida albicans* has occurred. When such an infection develops, it may require treatment with appropriate local therapy and discontinuation of treatment with Dymista Nasal Spray. Patients using Dymista Nasal Spray over several months or longer should be examined periodically for evidence of *Candida* infection or other signs of adverse effects on the nasal mucosa.

5.3 Glaucoma and Cataracts

Nasal and inhaled corticosteroids may result in the development of glaucoma and/or cataracts. Therefore, close monitoring is warranted in patients with a change in vision or with a history of increased intraocular pressure, glaucoma, and/or cataracts.

Glaucoma and cataract formation were evaluated with intraocular pressure measurements and slit 56 lamp examinations in a controlled 12-month study in 612 adolescent and adult patients aged 12 years and older with perennial allergic or vasomotor rhinitis (VMR). Of the 612 patients enrolled in the study, 405 were randomized to receive Dymista Nasal Spray (1 spray per nostril twice daily) and 207 were randomized to receive flutcasone propionate nasal spray (2 sprays per nostril once daily). In the Dymista Nasal Spray group, one patient had increased intraocular pressure at month 6. In addition, three patients had evidence of posterior subcapsular cataract at month 6 and one at month 12 (end of treatment). In the fluticasone propionate group, three patients had evidence of posterior subcapsular cataract at month 12 (end of treatment).

5.4 Immunosuppression

Persons who are using drugs, such as corticosteroids, that suppress the immune system are more susceptible to infections than healthy individuals. Chickenpox and measles, for example, can have a more serious or even fatal course in susceptible children or adults using corticosteroids. In children or adults who have not had these diseases or been properly immunized, particular care should be taken to avoid exposure. How the dose, route, and duration of corticosteroid administration affect the risk of developing a disseminated infection is not known. The contribution of the underlying disease and/or prior corticosteroid treatment to the risk is also not known. If exposed to chickenpox, prophylaxis with varicella zoster immune globulin (VZIG) may be indicated. If exposed to measles, prophylaxis with pooled intramuscular immunoglobulin 74 (IG) may be indicated. (See the respective package inserts for complete VZIG and IG prescribing information.) If chickenpox develops, treatment with antiviral agents may be considered.

Corticosteroids should be used with caution, if at all, in patients with active or quiescent tuberculous infections of the respiratory tract; untreated local or systemic fungal or bacterial infections; systemic viral or parasitic infections; or ocular herpes simplex because of the potential for worsening of these infections.

5.5 Hypothalamic-Pituitary-Adrenal (HPA) Axis Effects

When intranasal steroids are used at higher than recommended dosages or in susceptible individuals at recommended dosages, systemic corticosteroid effects such as hypercorticism and adrenal suppression may appear. If such changes occur, the dosage of Dymista Nasal Spray should be discontinued slowly, consistent with accepted procedures for discontinuing oral corticosteroid therapy. The concomitant use of intranasal corticosteroids with other inhaled corticosteroid scould increase the risk of signs or symptoms of hypercorticism and/or suppression of the HPA axis. The replacement of a systemic corticosteroid with a topical corticosteroid can be accompanied by signs of adrenal insufficiency, and in addition some patients may experience symptoms of withdrawal, e.g., joint and/or muscular pain, lassitude, and depression. Patients previously treated for prolonged periods with systemic corticosteroids and transferred to topical corticosteroids should be carefully monitored for acute adrenal insufficiency in response to stress. In those patients who have asthma or

other clinical conditions requiring long-term systemic corticosteroid treatment, too rapid a decrease in systemic corticosteroids may cause a severe exacerbation of their symptoms.

5.6 Use of Cytochrome P450 3A4 Inhibitors

Ritonavir and other strong cytochrome P450 3A4 (CYP3A4) inhibitors can significantly increase plasma fluticasone propionate exposure, resulting in significantly reduced serum cortisol concentrations [*see Drug Interactions (7.2) and Clinical Pharmacology (12.3)*]. During postmarketing use, there have been reports of clinically significant drug interactions in patients receiving fluticasone propionate and ritonavir, resulting in systemic corticosteroid effects including Cushing syndrome and adrenal suppression. Therefore, coadministration of Dymista Nasal Spray and ritonavir is not recommended unless the potential benefit to the patient outweighs the risk of systemic corticosteroid side effects.

Use caution with the coadministration of Dymista Nasal Spray and other potent CYP3A4 inhibitors, such as ketoconazole [see Drug Interactions (7.2) and Clinical Pharmacology (12.3]].

5.7 Effect on Growth

Corticosteroids may cause a reduction in growth velocity when administered to pediatric patients. Monitor the growth routinely of pediatric patients receiving Dymista Nasal Spray [see Use in Specific Populations (8.4)].

6 ADVERSE REACTIONS

Systemic and local corticosteroid use may result in the following:

- Somnolence [see Warnings and Precautions (5.1)]
- Local nasal effects, including epistaxis, nasal ulceration, nasal septal perforation, impaired wound healing, and *Candida albicans* infection [see Warnings and Precautions (5.2)]
- · Cataracts and glaucoma [see Warnings and Precautions (5.3)]
- Immunosuppression [see Warnings and Precautions (5.4)]
- Hypothalamic-pituitary-adrenal (HPA) axis effects, including growth reduction [see Warnings and Precautions (5.5 and 5.7), Use in Specific Populations (8.4)]

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect rates observed in practice. The safety data described below reflect exposure to Dymista Nasal Spray in 853 patients (12 years of age and older; 36% male and 64% female) with seasonal allergic rhinitis in 3 doubleblind, placebo-controlled clinical trials of 2-week duration. The racial distribution for the 3 clinical trials was 80% white, 16% black, 2% Asian, and 1% other. In the 12-month open-label, active-controlled clinical trial, 404 Asian patients (240 males and 164 females) with perennial allergic rhinitis or vasomotor rhinitis were treated with Dymista Nasal Spray, 1 spray per nostril twice daily.

Adults and Adolescents 12 Years of Age and Older

In the 3 placebo-controlled clinical trials of 2-week duration, 3411 patients with seasonal allergic rhinitis were treated with 1 spray per nostril of Dymista Nasal Spray, azelastine hydrochloride nasal spray, fluticasone propionate nasal spray, or placebo, twice daily. The azelastine hydrochloride and fluticasone propionate comparators use the same vehicle and device as Dymista Nasal Spray and are not commercially marketed. Overall, adverse reactions were 16% in the Dymista Nasal Spray treatment groups, 15% in the azelastine hydrochloride nasal spray groups, 13% in the fluticasone propionate nasal spray groups, and 12% in the placebo groups. Overall, 1% of patients in both the Dymista Nasal Spray and placebo groups discontinued due to adverse reactions.

Table 1 contains adverse reactions reported with frequencies greater than or equal to 2% and more frequently than placebo in patients treated with Dymista Nasal Spray in the seasonal allergic rhinitis controlled clinical trials.

Table 1. Adverse Reactions with >2% Incidence and More Frequently than

Placebo in Placebo-Controlled Trials of 2 Weeks Duration with Dymista Nasal Spray in Adult and Adolescent Patients With Seasonal Allergic Rhinitis						
	1 spray per nostril twice daily					
	Dymista Nasal Spray			Vehicle Placebo		
	(N=853)*	(N=851)	(N=846)	(N=861)		
Dysgeusia	30 (4%)	44 (5%)	4 (1%)	2 (<1%)		
Headache	18 (2%)	20 (2%)	20 (2%)	10 (1%)		
Epistaxis	16 (2%)	14 (2%)	14 (2%)	15 (2%)		

*Safety population N=853, intent-to-treat population N=848

⁺Not commercially marketed

In the above trials, somnolence was reported in <1% of patients treated with Dymista Nasal Spray (6 of 853) or vehicle placebo (1 of 861) [see Warnings and Precautions (5.1)].

Long-Term (12-Month) Safety Trial:

In the 12-month, open-label, active-controlled, long-term safety trial, 404 patients (12 years of age and older) with perennial allergic rhinitis or vasomotor rhinitis were treated with Dymista Nasal Spray 1 spray per nostril twice daily and 207 patients were treated with fluticasone propionate nasal spray, 2 sprays per nostril once daily. Overall, adverse reactions were 47% in the Dymista Nasal Spray treatment group and 44% in the fluticasone propionate nasal spray group. The most frequently reported adverse reactions (≥ 2%) with Dymista Nasal Spray were headache, pyrexia, cough, nasal congestion, rhinitis, dysgeusia, viral infection, upper respiratory tract infection, pharyngitis, pain, diarrhea, and epistaxis. In the Dymista Nasal Spray treatment

group, 7 patients (2%) had mild epistaxis and 1 patient (<1%) had moderate epistaxis. In the fluticasone propionate nasal spray treatment group 1 patient (<1%) had mild epistaxis. No patients had reports of severe epistaxis. Focused nasal examinations were performed and no nasal ulcerations or septal perforations were observed. Eleven of 404 patients (3%) treated with Dymista Nasal Spray and 6 of 207 patients (3%) treated with fluticasone propionate nasal spray discontinued from the trial due to adverse events.

7 DRUG INTERACTIONS

No formal drug interaction studies have been performed with Dymista Nasal Spray. The drug interactions of the combination are expected to reflect those of the individual components.

7.1 Central Nervous System Depressants

Concurrent use of Dymista Nasal Spray with alcohol or other central nervous system depressants should be avoided because somnolence and impairment of central nervous system performance may occur [see Warnings and Precautions (5.1)].

7.2 Cytochrome P450 3A4

Ritonavir (a strong CYP3A4 inhibitor) significantly increased plasma fluticasone propionate exposure following administration of fluticasone propionate aqueous nasal spray, resulting in significantly reduced serum cortisol concentrations [*see Clinical Pharmacology (12.3)*]. During postmarketing use, there have been reports of clinically significant drug interactions in patients receiving fluticasone propionate and ritonavir, resulting in systemic corticosteroid effects including Cushing syndrome and adrenal suppression. Therefore, coadministration of fluticasone propionate and ritonavir is not recommended unless the potential benefit to the patient outweighs the risk of systemic corticosteroid side effects.

Ketoconazole (also a strong CYP3A4 inhibitor), administered in multiple 200 mg doses to steady-state, increased plasma exposure of fluticasone propionate, reduced plasma cortisol AUC, but had no effect on urinary excretion of cortisol, following administration of a single 1000 mcg dose of fluticasone propionate by oral inhalation route.

Caution should be exercised when Dymista Nasal Spray is coadministered with ketoconazole and other known strong CYP3A4 inhibitors.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Dymista Nasal Spray: Teratogenic Effects: Pregnancy Category C:

There are no adequate and well-controlled clinical trials of Dymista Nasal Spray, azelastine hydrochloride only, or fluticasone propionate only in pregnant women. Animal reproductive studies of azelastine hydrochloride and fluticasone propionate in mice, rats, and/or rabbits revealed evidence of teratogenicity as well as other developmental toxic effects. Because animal reproduction studies are not always predictive of human response, Dymista Nasal Spray should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Azelastine hydrochloride: Teratogenic Effects: In mice, azelastine hydrochloride caused embryo-fetal death, malformations (cleft palate; short or absent tail; fused, absent or branched ribs), delayed ossification, and decreased fetal weight at an oral dose approximately 610 times the maximum recommended human daily intranasal dose (MRHDID) in adults (on a mg/m2 basis at a maternal dose of 68.6 mg/kg). This dose also caused maternal toxicity as evidenced by decreased body weight. Neither fetal nor maternal effects occurred at a dose that was approximately 26 times the MRHDID (on a mg/m2 basis at a maternal dose of 3 mg/kg).

In rats, azelastine hydrochloride caused malformations (oligo- and brachydactylia), delayed ossification and skeletal variations, in the absence of maternal toxicity, at an oral dose approximately 530 times the MRHDID in adults (on a mg/m2 basis at a maternal dose of 30 mg/kg). At a dose approximately 1200 times the MRHDID (on a mg/m2 basis at a maternal dose of 68.6 mg/kg), azelastine hydrochloride also caused embryo-fetal death and decreased fetal weight; however, this dose approximately 53 times the MRHDID (on a mg/m2 basis at a maternal effects occurred at a dose approximately 53 times the MRHDID (on a mg/m2 basis at a maternal dose of 3 mg/kg).

In rabbits, azelastine hydrochloride caused abortion, delayed ossification, and decreased fetal weight at oral doses approximately 1100 times the MRHDID in adults (on a mg/ m2 basis at a maternal dose of 30 mg/kg); however, these doses also resulted in severe maternal toxicity. Neither fetal nor maternal effects occurred at a dose approximately 11 times the MRHDID (on a mg/m2 basis at a maternal dose of 0.3 mg/kg).

Fluticasone propionate: Teratogenic Effects: Corticosteroids have been shown to be teratogenic in laboratory animals when administered systemically at relatively low dosage levels. Subcutaneous studies in the mouse and rat at doses approximately equivalent to and 4 times, respectively, the MRHDID in adults (on a mcg/m2 basis at maternal doses of 45 and 100 mcg/kg respectively), revealed fetal toxicity characteristic of potent corticosteroid compounds, including embryonic growth retardation, omphalocele, cleft palate, and retarded cranial ossification.

In the rabbit, fetal weight reduction and cleft palate were observed at a subcutaneous dose less than the MRHDID in adults (on a mcg/m2 basis at a maternal dose of 4 mcg/kg). However, no teratogenic effects were reported at oral doses up to approximately 25 times the MRHDID in adults (on a mcg/m2 basis at a maternal dose of 300 mcg/kg) of fluticasone propionate to the rabbit. No fluticasone propionate was detected in the plasma in this study, consistent with the established low bioavailability following oral administration [see Clinical Pharmacology (12.3]].

Experience with oral corticosteroids since their introduction in pharmacologic, as opposed to physiologic, doses suggests that rodents are more prone to teratogenic effects from corticosteroids than humans. In addition, because there is a natural increase in corticosteroid production during pregnancy, most women will require a lower exogenous corticosteroid dose and many will not need corticosteroid treatment during pregnancy.

Nonteratogenic Effects: Fluticasone propionate crossed the placenta following oral administration of approximately 4 and 25 times the MRHDID in adults (on a mcg/m2 basis at maternal doses of 100 mcg/kg and 300 mcg/kg to rats and rabbits, respectively).

8.3 Nursing Mothers

Dymista Nasal Spray: It is not known whether Dymista Nasal Spray is excreted in human breast milk. Because many drugs are excreted in human milk, caution should be exercised when Dymista Nasal Spray is administered to a nursing woman. Since there are no data from well-controlled human studies on the use of Dymista Nasal Spray by nursing mothers, based on data from the individual components, a decision should be made whether to discontinue nursing or to discontinue Dymista Nasal Spray, taking into account the importance of Dymista Nasal Spray to the mother.

Azelastine hydrochloride: It is not known if azelastine hydrochloride is excreted in human milk.

Fluticasone propionate: It is not known if fluticasone propionate is excreted in human milk. However, other corticosteroids are excreted in human milk. Subcutaneous administration to lactating rats of 10 mcg/kg of tritiated fluticasone propionate (less than the maximum recommended daily intranasal dose in adults on a mcg/m2 basis) resulted in measurable radioactivity in the milk.

8.4 Pediatric Use

Safety and effectiveness of Dymista Nasal Spray in pediatric patients below the age of 12 years have not been established.

Controlled clinical studies have shown that intranasal corticosteroids may cause a reduction in growth velocity in pediatric patients. This effect has been observed in the absence of laboratory evidence of HPA axis suppression, suggesting that growth velocity is a more sensitive indicator of systemic corticosteroid exposure in pediatric patients than some commonly used tests of HPA axis function. The long-term effects of this reduction in growth velocity associated with intranasal corticosteroids, including the impact on final adult height, are unknown. The potential for "catch-up" growth following discontinuation of treatment with intranasal corticosteroids has not been adequately studied. The growth of pediatric patients receiving intranasal corticosteroids, including Dymista Nasal Spray, should be monitored routinely (e.g., via stadiometry). The potential growth effects of prolonged treatment should be weighed against the clinical benefits obtained and the risks/benefits of treatment atternatives.

8.5 Geriatric Use

Clinical trials of Dymista Nasal Spray did not include sufficient numbers of patients 65 years of age and older to determine whether they respond differently from younger patients. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

10 OVERDOSAGE

Dymista Nasal Spray: Dymista Nasal Spray contains both azelastine hydrochloride and fluticasone propionate; therefore, the risks associated with overdosage for the individual components described below apply to Dymista Nasal Spray.

Azelastine hydrochloride: There have been no reported overdosages with azelastine hydrochloride. Acute azelastine hydrochloride overdosage by adults with this dosage form is unlikely to result in clinically significant adverse events, other than increased somnolence, since one (1) 23 g bottle of Dymista Nasal Spray contains approximately 23 mg of azelastine hydrochloride. Clinical trials in adults with single doses of the oral formulation of azelastine hydrochloride (up to 16 mg) have not resulted in increased incidence of serious adverse events. General supportive measures should be employed if overdosage occurs. There is no known antidote to Dymista Nasal Spray. Oral ingestion of antihistamines has the potential to cause serious adverse effects in children. Accordingly, Dymista Nasal Spray should be kept out of the reach of children.

Fluticasone propionate: Chronic fluticasone propionate overdosage may result in signs/ symptoms of hypercorticism [*see Warnings and Precautions (5.2*]]. Intranasal administration of 2 mg (10 times the recommended dose) of fluticasone propionate twice daily for 7 days to healthy human volunteers was well tolerated. Single oral fluticasone propionate doses up to 16 mg have been studied in human volunteers with no acute toxic effects reported. Repeat oral doses up to 80 mg daily for 10 days in volunteers and repeat oral doses up to 10 mg daily for 14 days in patients were well tolerated. Adverse reactions were of mild or moderate severity, and incidences were similar in active and placebo treatment groups. Acute overdosage with this dosage form is unlikely since one (1) 23 g bottle of Dymista Nasal Spray contains approximately 8.5 mg of fluticasone propionate.



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eeling a bit overwhelmed by all the recent changes in healthcare? Would you, your practice, and your patients benefit from hearing "insider" information on the new reforms associated with the Affordable Care Act (ACA)? Curious how your colleagues are handling these changes? Tired of legislators making decisions for you? Are you ready to make a difference?

If you answered "yes" to any of the above questions, we have the answer. The AAO-HNS is excited to host the 2013 BOG Spring Meeting & OTO Advocacy Summit (May 5-7) in Alexandria, VA, and Washington, DC. This year's combined meeting will provide a great opportunity for attendees to hear from experienced policymakers, participate in committee meetings, attend networking events, and meet with your legislators on Capitol Hill. Even better—this event is free for AAO-HNS members!

BOG Spring Meeting

The Board of Governors (BOG) Spring Meeting offers attendees the opportunity to learn more about the grassroots arm of the Academy, network, and engage in peer-topeer interactions with eminent members in the field. Information sharing and presentations from a variety of dynamic speakers and subject-matter experts will be featured throughout the BOG portion of the combined meeting. Attendees will also benefit from a comprehensive review of important issues affecting otolaryngology practices in today's rapidly changing healthcare environment, as society representatives from across the nation gather to discuss national, state, and local issues of importance.

On the morning of Sunday, May 5, the meeting begins with an icebreaker event followed by the first of our BOG committee meetings. For Sunday's luncheon, the BOG Executive Committee has invited Wendy B. Stern, MD, chair of the Media and Public Relations Committee and BOG secretary. Dr. Stern will present a panel discussion on how social media in academic and private practice settings can be a great benefit, and ways to avoid unnecessary risks to physicians, their practice, and/or academic setting. The day will continue with committee meetings highlighting hot topics, including an overview of the current legislative environment at the state and federal levels, a discussion of how to reenergize our BOG societies, and pediatric

subcertification. Issues of reimbursement, specialty unity, health system reform, and the shrinking otolaryngology workforce will figure prominently in these committee discussions.

Immediately following the Sunday sessions, you are invited to a Professional Education Focus Group. Tell us what you think about the Foundation's professional education efforts. We are looking for a representative sample of members to talk about how to enhance and improve upon current education offerings and to better serve the education needs of our members. Look for more information about the focus groups with BOG Spring Meeting information.

On Sunday evening, ENT PAC, the political action committee of the AAO-HNS, will host a reception open to all 2013 ENT PAC Leadership Club donors. Reception attendees will be treated to a scenic evening boat cruise on the Potomac River while mingling with colleagues and enjoying heavy hors d'oeuvres and refreshments. Don't miss this opportunity to see Washington, DC, from a perspective most visitors would envy.

On Monday, May 6, the meeting begins with a "society information sharing" session where BOG committee chairs will provide



updates about their committee activities since the last annual meeting and plans for the upcoming meeting in Vancouver. Shortly thereafter, the BOG General Assembly will feature the always lively president-elect "Candidates Forum," which offers attendees the opportunity to question the candidates for AAO-HNS/F presidentelect. The BOG portion of the combined meeting will conclude with a luncheon featuring keynote speaker, Wendy Kroll, JD, who will present on the legal implications of the Affordable Care Act on an ENT practice.

OTO Advocacy Summit

Following the BOG luncheon on Monday, May 6, the Summit will officially begin by transitioning into an in-depth advocacy briefing conducted by members of the AAO-HNS Government Affairs team. Legislative priorities will be highlighted, including "truth in advertising," Medicare physician payment reform, repeal of the Independent Payment Advisory Board, and scope of practice. AAO-HNS members also will be equipped with key talking points to fully brief Members of Congress and/or Congressional staff on the legislative issues important to the specialty.

Immediately following the advocacy briefing, Summit attendees will hear presentations by Congressional and Administration speakers who will offer an "insider's" view into the policymaking process and the current proposals being debated in Washington, DC. Ample time will be provided to ensure a robust Q&A session between our guest speakers and Summit attendees.

On Tuesday, the Summit will culminate with a full day of meetings with Members of Congress and/or their staffs. After an early morning final briefing, Summit attendees will be transported from Alexandria to the AAO-HNS Washington, DC, office on Capitol Hill. Following a quick group photo on the steps of the U.S. Capitol, AAO-HNS members will participate in pre-scheduled meetings with their House and Senate legislators. This unique and invigorating opportunity will enable Summit participants to showcase their insight and expertise in patient care, while communicating the key legislative priorities for the specialty.

Attendees are invited back to the AAO-HNS Capitol Hill office in between or after their Hill visits to provide feedback to Academy staff on their meetings. Lunch and refreshments will be provided for all members. To ensure sufficient time to attend all your Hill meetings, attendees are requested to plan their flight departures after 4 pm.

Sign Me Up!

Interested in attending? Academy members can register online for the BOG Spring Meeting & OTO Advocacy Summit by visiting www.entnet.org/ BOG&Summit. Other important information can also be found on this site, including tentative agendas, resident leadership travel grant applications, and directions on ways to book your hotel reservation at the meeting's host hotel, the Embassy Suites Alexandria Hotel.

Don't delay: Act now to participate. The 2013 BOG Spring Meeting & OTO Advocacy Summit is a unique way for members to learn more about the Academy and influence federal legislation affecting the specialty, your patients, and your practice. Make sure to take advantage of this free member benefit and register today. We hope to see you in May!

Home Is Where the Votes Are: In-District Grassroots Outreach (I-GO)

he AAO-HNS is continually advocating on behalf of its members and the specialty by monitoring legislation, writing comment letters to state and federal legislators, and by supporting pro-otolaryngology candidates for federal office through ENT PAC, the Academy's political action committee. However, when dealing with elected officials, the most effective way to "lobby" on legislative issues is through you, our members, who are viewed as voters and constituents by legislators.

Each year, a group of our dedicated members comes to Washington, DC, during the OTO Advocacy Summit and meets with their Members of Congress. These meetings are always professional and informative to the representatives and their staffs. However, after the meetings conclude, these officials often do not hear from our members for another 364 days.

In order to amplify the voice of the specialty, and to be heard for more than just one day, the Academy is launching its In-district Grassroots Outreach (I-GO) program. The main goal of I-GO is to engage members with their state and federal officials at home in their legislative districts. This helps Academy members to have their voices heard more frequently without the need to travel to Washington, DC, and it provides representatives with a helpful resource at home.

How Do I Get Involved?

■ Town Halls and Office Visits

By far, the most effective method of advocating on behalf of otolaryngology– head and neck surgery is meeting faceto-face with policymakers. Legislators make this possible through periodically holding town halls or by hosting open office hours in their district offices, so their constituents can meet with them directly. The best way to learn about these events is to read your local paper or by reaching out to your official's office. Or, simply email AAO-HNS The main goal of I-GO is to engage members with their state and federal officials at home in their legislative districts

Government Affairs at govtaffairs@ entnet.org, and we can assist in your outreach.

Fundraisers

One constant in politics is the need to raise money. Whether it is federal or state politics, all politicians must hold fundraisers to get the resources they need to make their case to voters. Generally, fundraisers are small gatherings, which means they are great opportunities to get "face time" with candidates. Also, due to the nature of the event, you are considered a friendly person they can listen to for counsel on the issues. If you are a current ENT PAC investor, email entpac@entnet.org, and your donation to attend a fundraising event may be covered.

■ Host a Legislator at Your Practice

You will often see elected officials visiting small or new businesses in your area on "site visits." These visits provide an opportunity for the official to hear directly from stakeholders and voters on certain legislation or regulations. They also provide a nice photo-op for any media that accompanies them to the location. Many physicians are more comfortable talking about healthcare issues on their own turf. Consider inviting a legislator to your office—a truly memorable and effective hands-on experience.

■ The Pen Is Mightier...

The majority of people who contact their elected officials write a letter or send an email. Legislators are well aware of this and monitor closely the issues being highlighted in their inboxes and mailboxes. A benefit of this method of communication is it is less time intensive than some of the other options. Here are some tips for effective letter writing:

- Share personal stories about your practice or training;
- Make a strong "ask" about what their position is/should be;
- Always keep a positive tone with no insults; and
- Make sure they know you are a physician/otolaryngologist/constituent/voter/business owner.

■ Write a Letter to the Editor

Everyone knows they need a physician; however, not everyone knows what a physician needs. Write a letter to your local paper, telling them about an issue that is being considered in Congress or your state legislature. Often, people are unaware of pending physician-related issues that could affect them, as patients, and the care they receive from their physicians. Also, since all public officials monitor their local media to see what is being discussed, it could help inform legislators as well.

■ Where Do I Begin?

First, if you are not a member of the ENT Advocacy Network (a free, yet rewarding, AAO-HNS member benefit) sign up today by emailing govtaffairs@entnet.org. Members of the Network are the first people to hear about public events in their area and are considered the "front line" for AAO-HNS Government Affairs efforts.

Second, visit the Legislative Grassroots at www.entnet.org/advocacy. This resource features updated state and federal talking points, guides on talking to elected officials, writing samples, and links to current grassroots programs. The grassroots page is a great guide to help you when interacting with public officials in certain situations and a great way to keep informed about our issues and talking points.

Finally, make sure to use the Government Affairs team as your resource. If you do not feel comfortable reaching out to a legislator's office or have questions about a topic, simply email govtaffairs@entnet.org or call 1-703-535-3795. The team stands ready to help you make a difference!

Alphabet Soup: Acronyms Advocates Need to Know

CBO: Congressional Budget Office. CBO produces independent analyses of budgetary and economic issues to support the Congressional budget process. CBO "scores" proposed bills to help lawmakers understand the cost or savings associated with a legislative package.

CHHC: Congressional Hearing Health Caucus. CHHC is a bipartisan caucus of members from the U.S. House and Senate committed to supporting the U.S. needs of people with hearing loss and other auditory disorders. The AAO-HNS is a member of the Friends of the CHHC.

CMS: Centers for Medicare & Medicaid Services. CMS is a federal agency within the U.S. Department of Health and Human Services. It is responsible for administering the Medicare program and working with states on administering their Medicaid programs.

DHHA: Deaf and Hard of Hearing Alliance. DHHA is a coalition that seeks changes to federal public policy to help improve the quality of life for people who are deaf, hard of hearing, or have hearing loss. The AAO-HNS is a member of DHHA.

HCLA: Health Coalition on Liability and Access. HCLA is a national advocacy coalition working to advance medical liability reform at the federal level. The AAO-HNS serves on the HCLA Board.

HIT: Health Information

Technology. Software and computer systems can now make medical records electronic, reducing paperwork and redundant forms. Federal and state governments are exploring numerous proposals to encourage the adoption of HIT while promoting quality initiatives and protecting patient privacy.

IPAB: Independent Payment Advisory Board. The IPAB is an unelected government body established under the Patient Protection and Affordable Care Act. It is responsible for reducing the rate of growth in Medicare without affecting its coverage or quality. The Board is scheduled to implement its first proposal in 2015, although this is likely to be delayed. The AAO-HNS supports repeal of the IPAB.

MedPAC: Medicare Payment Advisory Commission. MedPAC is an independent federal body established by the Balanced Budget Act of 1997. It is responsible for advising Congress on topics within the Medicare program, and more specifically, on issues dealing with payments to private health plans participating in Medicare and health providers that serve Medicare beneficiaries.

MLR: Medical Liability Reform. MLR is a critical healthcare reform issue in the U.S. and a legislative priority for the AAO-HNS. Proponents of MLR are working to implement or amend legislation to lessen/cap excessive liability insurance costs for physicians while ensuring fair compensation for patients injured by negligent actions.

PAC: Political Action Committee. PACs allow individuals with shared interests the opportunity to pool their voluntary donations to make contributions to federal candidates on behalf of the entire group. PACs represent a legal and ethical way to participate in the election process. ENT PAC (www. entpac.org) is the political action committee of the AAO-HNS.

SGR: Sustainable Growth Rate. The SGR formula is a flawed expenditure target against which healthcare costs are compared. Generally, if annual healthcare costs fall below the target, Medicare reimbursement rates are increased. Conversely, if annual healthcare costs exceed the target, Medicare payment rates are decreased to reduce costs. Since healthcare costs tend to grow faster than the rate of inflation, the flawed formula has historically triggered annual Medicare physician payment cuts, which have typically been averted by Congressional action. The AAO-HNS supports repeal of the SGR formula.

TIA: Truth in Advertising. The AAO-HNS and others in the physician community support state and federal efforts to implement TIA legislation requiring all healthcare providers to inform patients of their credentials and/ or level of training in patient communications and marketing materials. Truth in advertising is an important component of providing patients with the best possible care.

Stay Informed: Bookmark the AAO-HNS Legislative and Political Affairs Webpage

Do you want to be one of the first to know the status of healthcare bills moving through Congress or your state? Bookmark the Legislative and Political Affairs webpage today! By visiting the page, you can learn more about the issues impacting the specialty, including the flawed Sustainable Growth Rate (SGR) formula, medical liability reform, scope-of-practice battles, Graduate Medical Education (GME) funding, truth-in-advertising initiatives, and efforts to repeal the Independent Payment Advisory Board (IPAB). Visit www.entnet.org/advocacy.

Overview: 2013 Federal Legislative Priorities

he American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS) is committed to the enactment of legislation that will strengthen the delivery of, and access to, quality healthcare. To that end, the AAO-HNS urges Congress to take the following actions in 2013:

Permanently Repeal the Sustainable Growth Rate (SGR) Formula

The volatility and instability of the Medicare payment system is threatening beneficiaries' access to healthcare. Continued payment cuts, rising practice costs, and a lack of certainty going forward make it difficult, if not impossible, for already financially challenged physician practices to continue to treat Medicare patients. During the past decade, the AAO-HNS and others in the physician community have repeatedly advocated for the reform and redesign of the unstable and unsustainable Medicare physician payment formula. However, Congress' failure to enact permanent reform has created an instability and uncertainty that undermines the ability of physicians to plan for the future, to provide for their employees, and to make investments to help improve the quality and efficiency of the care they provide. No true success in the healthcare reform and/or deficit reduction arenas can be achieved without the concurrent repeal of the SGR formula and development of a new Medicare physician payment model. Members of Congress are urged to support the permanent repeal of the flawed SGR formula.

Protect Patient Safety Within the Medicare Program

The AAO-HNS strongly believes a physician-led hearing healthcare team with coordination of services is the best approach for providing the highest quality care to patients. In past years, some in the audiology community have pursued unlimited direct access to Medicare patients without a physician referral, and the AAO-HNS has repeatedly opposed such legislative efforts due to significant patient safety concerns. In addition, some audiologists now seek to amend Title XVIII (18) of the Social Security Act to achieve a "limited license physician" status within the Medicare program. Hearing and balance disorders are medical conditions that require a full patient history and physical examination by a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO). While audiologists play a critical role in providing quality-hearing healthcare, their desire to independently diagnose hearing disorders transcends their level of training and expertise. Members of Congress are urged to oppose "direct access" to audiologists without a physician referral and proposed Title XVIII expansions to ensure patient safety is preserved.

Repeal the Independent Payment Advisory Board (IPAB)

The IPAB, an unaccountable body of individuals appointed by the President and charged with creating Medicare payment policy, usurps the rightful authority of our elected Congressional officials to create and shape Medicare policy. By limiting Congressional authority, the IPAB essentially eliminates the transparency of hearings, debate, and the meaningful opportunity of stakeholder input. In fact, fewer than half of the IPAB members can be healthcare providers, and none are permitted to be practicing physicians or be otherwise employed. Members of Congress are encouraged to support the introduction and passage of legislation to repeal the Independent Payment Advisory Board.

Enact Comprehensive Medical Liability Reforms

The nation's current medical liability system places patients in jeopardy of losing their access to vital healthcare services. With affordable and adequate medical liability insurance becoming difficult to find, physicians are retiring early, limiting their practices, or moving

to states with less costly premiums. This disturbing trend is leaving entire communities without access to critical healthcare services. As a specialty, in an effort to reduce and learn from instances of medical error, we have committed substantial resources to and engaged our members in proactive quality improvement initiatives. However, further statutory changes are necessary to address flaws in our current tort system and enact proven reforms to reduce frivolous lawsuits. Members of Congress are urged to explore innovative solutions to alleviate the burdens associated with the current medical liability system.

Support Clarity and Transparency in Healthcare Advertisements

Currently, there is little "transparency" associated with the most fundamental and important component of healthcare delivery-the many health professionals who interact with patients every day. Recent studies confirm America's patients prefer a physician-led approach to healthcare and are often confused about the level of training and education of their healthcare providers. Because of this uncertainty, patient autonomy and decision-making have been compromised. America's patients deserve to be fully informed and able to easily identify in healthcare advertisements their providers' credentials, licenses, and training when seeking treatment. Members of Congress are urged to support legislation designed to require ALL healthcare providers to provide critical credentialing/training information in healthcare advertisements and during patient interactions.

For more information on AAO-HNS federal legislative priorities, contact the Government Affairs team at legfederal@entnet.org.

*Priorities are subject to change as the year continues. Check back on the Government Affairs webpage (www.entnet.org/advocacy) for updates.

Overview: 2013 State Legislative Priorities

ach year, the AAO-HNS reviews thousands of bills introduced in legislatures across the nation to determine relevancy to the specialty. Of those bills, the AAO-HNS actively tracks hundreds of pieces of legislation at any given time. The following is a brief summary of some of the Academy's state legislative priorities for 2013. For a more detailed listing of the issues/bills being monitored by the AAO-HNS, visit www.entnet.org/Practice/ members/stateAdvocacy.cfm.

Scope of Practice

The AAO-HNS believes it is appropriate for non-physician providers to seek updates to statutes and regulations relating to their defined scope of practice to reflect advances in education and training.

However, the AAO-HNS strongly opposes state legislation that would inappropriately expand the scope of practice of non-physician providers beyond their education and training. Enabling non-physician providers to independently diagnose, treat, or manage medical disorders could adversely affect the quality of patient care.

Hearing Aid Services

The coverage of, sale, and dispensing of hearing aids is an issue considered by several states in various forms each legislative year. The AAO-HNS tracks a number of bills that address the scope of practice of dispensing hearing aids, state insurance mandates for hearing aids, and the tax credits and/or exemptions for hearing aids.

Taxes on Medical Procedures

Each year, there is a re-emergence of proposals to tax medical procedures. In light of continuing state budget shortfalls, 2013 will likely be no exception. The Stop Medical Taxes Coalition, of which the AAO-HNS is a member, asserts that the taxation of medical procedures is unfair for patients, violates patient privacy, requires physicians to be tax collectors, and is a "slippery slope" toward the taxation of other medical services.

Truth in Advertising

With the emergence of clinical doctorate programs for non-physician providers, which has led to many degree holders referring to themselves as "doctors," there is growing confusion within the patient population about the level of training and education of their healthcare providers. The AAO-HNS continues to advocate for increased transparency and clarity in patient communications and interactions to help avoid confusion in the healthcare delivery system.

Tobacco Use and Smoking Cessation

The AAO-HNS supports legislation and regulations that will help to reduce the use of tobacco products and exposure to secondhand smoke in order to promote healthy environments and lifestyles for the public. The AAO-HNS tracks legislation that seeks to strengthen or weaken smoking ban laws, as well as proposals to mandate insurance coverage and/or benefits for tobacco cessation.

Medical Liability Reform

Each year, numerous states consider various tort reform measures, including those related to affidavits of merit, alternative reforms, caps on non-economic damages, defensive medicine costs, expert witnesses, health courts, and/or pre-trial screening panels. The AAO-HNS strongly supports comprehensive medical liability reforms to stabilize and reduce professional liability premiums, ensure continued access to care by patients, and eliminate frivolous lawsuits.

For more information on state legislative issues or specific measures, contact legstate@entnet.org or 1-703-535-3794.

*Priorities are subject to change as the year continues. Check back on the Government Affairs webpage (www.entnet.org/advocacy) for updates.

Follow AAO-HNS Government Affairs on Twitter

To provide AAO-HNS members with quick and timely updates, the Government Affair's Twitter account will now be used as a

primary method for distributing breaking news. Follow us @ AAOHNSGovtAffrs today!





ENT PAC, the political action committee of the AAO-HNS, financially supports federal Congressional candidates and incumbents who advance the issues important to otolaryngology–head and neck surgery. ENT PAC is a nonpartisan, issue-driven entity that serves as your collective voice on Capitol Hill and helps to increase the visibility of the specialty with key policymakers. To learn more about ENT PAC, visit our new PAC website at www.entpac.org (log-in with your AAO-HNS ID and password).

DRY NASAL ALLERGY SPRAYS Return as a treatment option

Into the 1990's dry-formula intranasal steroid (INS) sprays comprised nearly 30% of the nasal allergy market.¹ And then, poof, they were gone. What happened? Many physicians had come to rely on them, including Eli Meltzer, MD, of the Allergy & Asthma Medical Group & Research Center in San Diego, California. "Many clinicians prescribed those corticosteroid nasal aerosol sprays more often than some other medications we had at that time."

The Montreal Protocol brought an end to the dry spray

The problem with the dry sprays was their propellant—chlorofluorocarbon (CFC). CFCs are known to be an ozone-depleting substance (ODS) and harmful to the environment.² The "Montreal Protocol on



Substances that Deplete the Ozone Layer" is an important international environmental treaty under which the US agreed to phase out the production and importation of ODSs. An exception to this rule was medical products that were determined to be "medically essential."³ Many asthma and chronic obstructive pulmonary disease (COPD) products fell into this category but nasal allergy sprays did not—and as of January 1, 1996, nonmedically essential products could no longer be manufactured.^{2,4}

Wet sprays attempted to fill the treatment void

With dry formula sprays no longer an option, doctors sought other solutions for their patients. "You can only use what you have available," said Dr. Meltzer. "On a personal level I preferred the aerosols, but they became less and less available, so we switched to the aqueous corticosteroid sprays, and they were

> On a personal level I preferred the (dry) aerosols, but they became less and less available..."

ELI MELTZER, MD effective." To this day, aqueous nasal sprays are a valuable treatment option for many patients. However, they are not without their issues.

NASAL study revealed patient dissatisfaction

In 2010, a landmark survey of allergic rhinitis patients and their physicians was conducted to assess how well patients were being managed.⁵ The National Allergy Survey Assessing Limitations (NASAL) revealed that many patients were dissatisfied with their current medication. Over 60% of surveyed patients who had used an INS spray in the past year reported that they experienced "medication drip back down the throat." Additionally, just over 18% of patients reported that they experienced "discomfort from spray." Nearly 1 in 5 nasal allergy sufferers asked their doctor to change their INS spray. Of those patients, 28% cited "bothersome side effects" as the cause of their dissatisfaction.

Dry sprays make a welcome return

In time, researchers developed a new, environmentally friendly aerosol propellant.² This was welcome news for physicians like Dr. Meltzer: "We were very pleased when HFA (hydrofluoroalkane) asthma inhalers became



available and we encouraged the pharmaceutical companies to develop them for nasal allergy treatment. It's nice to say that we now have a couple of dry spray options. I liked them when they were first available, I preferred them when I had access to both the aqueous and the aerosol, and I still prefer them today." Many patients may also agree. "There are patients who prefer one over the other, and it's important to individualize treatment. I consider the dry sprays for patients who have a great amount of nasal drainage or blockage, or for patients who prefer something that doesn't have sensory attributes," said Dr. Meltzer.

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Fighting an Antiquated Law: Hearing Aid Dispensing in New York

n New York State, under current law, few physicians offer hearing aid services within their practices, as it is not economically feasible to do so. The result is limited patient choice and reduced access to quality hearing healthcare for patients.

The Patient Access to Hearing Aids (PAHA) coalition, comprised of state and national medical and specialty organizations, was formed to educate New York legislators, patients, and otolaryngologists about an archaic law in New York prohibiting physicians from dispensing hearing aids for a profit and to advocate for change. Building on our momentum from previous years, the coalition is at a critical juncture to change this outdated law and make a difference in New York.

Earlier this year, Assemblyman Jeffrey Dinowitz and Sen. Betty Little reintroduced A. 655/S. 3055. If adopted, these bills would expand patient access to treatment services by enabling physician offices to dispense hearing aids for a profit.

There are several advantages to patients being able to attain hearing aids in a physician's office, including continuity of medical care and convenience for the consumer. The ability to treat both a patient's medical and audiological needs at the same office location often results in better patient care. Patients can receive a medical determination on the cause of their hearing loss and have their treatment overseen by a medical doctor. This reduces the need for multiple visits to different providers, which can cost a patient in both time and resources, and would allow patients to receive the full spectrum of treatment in one location.

In addition, the passage of A. 655/S. 3055 would allow patients the freedom to choose their provider. Because this prohibition exists in New York, many otolaryngologists and other physicians—despite being fully qualified to dispense hearing aids—have had to tailor their practices to transfer a whole segment of their patients to hearing aid dispensers and independent



audiologists, who can (and do) profit from the sale of hearing instruments. Thus, the patient's freedom to choose the best provider for their needs is eliminated. Many patients prefer to have their hearing aids fitted by their otolaryngologist or an audiologist employed by their physician. This is especially true for patients with complicated or severe otological needs.

Also, due to basic market principles of supply and demand, the improved choice for consumers and increased competition among providers would help lower the cost of hearing aids for patients. Unlike some other dispensers, physicians have little profit motive for one method of treatment over the other, and will focus on the right treatment for the problem—whether it be medical, surgical, or through the dispensing of hearing aids.

Now is the time to act to repeal this antiquated practice in New York. This month, the New York State Society of Otolaryngology-Head and Neck Surgery (NYSSO), will conduct its annual State Lobby Day in conjunction with the New York Coalition of Specialty Care Physicians on Tuesday, April 23, in Albany. Efforts to advance A. 655/S. 3055 will be a key item on the agenda. **A good** turnout is critical to effectively advocate for patients and the profession, so all New York otolaryngologists are urged to participate in Albany on April 23. For additional details and a registration form, please contact the NYSSO office at 1-518-439-2020 or nyssohns@aol.com.

For more information on the PAHA Coalition and its legislative efforts, visit the PAHA Coalition website at http:// www.entnet.org/Practice/members/PAHA. cfm (AAO-HNS member log-in required). With questions, contact the AAO-HNS Government Affairs team at legstate@ entnet.org.

*The PAHA Coalition includes the AAO-HNS and the New York State Society of Otolaryngology-Head and Neck Surgery (NYSSO), along with the Medical Society of the State of New York (MSSNY), the American Medical Association (AMA), the American Osteopathic Association, the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery, the American Otological Society, American Academy of Pediatrics, District II, Association of Otolaryngology Administrators, Ear Professionals International Corporation, New York Coalition of Specialty Care Physicians, and the New York State Osteopathic Medical Society.

3P Update: EHR Cloning and Provider Responsibility

he Physician Payment Policy Workgroup (3P), co-chaired by James C. Denneny III, MD, and Michael Setzen, MD, is the senior advisory body to Academy leadership and staff on issues related to socioeconomic advocacy, regulatory activity, coding or reimbursement, and practice services or management. 3P wants members to take note that 2013 represents a shift in the use of Electronic Health Records (EHR) as the program administered by the Centers for Medicare & Medicaid Services (CMS) incorporate penalties for unsuccessful participants for the first time.

Reporting in 2013 will be used to determine whether or not an eligible professional will be subjected to a one percent Medicare payment reduction in 2015. These penalties increase annually as the program advances. Penalties and incentives are determined on an annual basis, meaning if a physician attests or fails to successfully attest in 2013, it only applies to the incentive payment in 2014, or the penalty assessed in 2015. It is important to note that you must continue to successfully report on an annual basis to avoid penalties and earn incentive payments.

How Are Your Colleagues Doing?

In the last few years, the Health Policy department has seen an increase in the number of physicians and eligible professionals utilizing EHRs in their practice. According to a December 2012 Centers for Disease Control and Prevention (CDC) report, 72 percent of office-based physicians used an EHR system in 2012, up from 48 percent in 2009. Forty percent of all office-based physicians said their system met the basic Office of the National Coordinator of Health Technology (ONC) and CMS certification criteria. This is an increase of 18 percent since 2009. The same report stated that 66 percent of office-based physicians reported that they planned to apply, or already had applied, for "meaningful use" incentives. Finally, 27 percent of office-based physicians who planned to apply or already had applied for meaningful use incentives had computerized systems with capabilities to support 13 of the "Stage 1 Core Set" objectives for meaningful use. See Figure 1.

The Academy supports the continued integration of EHRs into the practices of otolaryngologist-head and neck surgeons and is working to continue to provide resources to members to best allow them to use EHRs and successfully participate in the CMS Medicare and Medicaid EHR Incentive Program. As this integration continues and increases in the coming years, physicians and their staff should be aware of the responsibilities they face with the implementation or continued use of an EHR in their practice and actively protect themselves and their practices. This article, while not designed to scare you or deter you from utilizing an EHR system, hopes instead to make you aware of potential issues so you can most effectively use your EHR to improve your practice while remaining vigilant to potential issues that can arise with the incorporation of an EHR system.

CMS Audits

Last summer, CMS began to send out letters to physicians notifying them they were chosen to be audited for their EHR Meaningful Use Stage 1 Incentive Payment. According to Jim Tate of the website HITECHAnswers, letters from the accounting firm Figliozzi and Company,

the contractor chosen to administer the EHR Audit program, asked physicians to provide "proof of possession of a certified EHR technology system... documentation that proves that 50 percent or more of patient encounters during the reporting period were entered into a Certified EHR Technology system," and "for both the Core and Menu Set **Objectives/Measures:**

% Use EHR

supporting documentation used during the attestation."

According to the law firm of Ober Kaler, these audits are not specifically targeting physicians, but appear to be sweeping audits to investigate incentive payments and possibly serve as the basis for future audit programs to maintain program integrity. It is important to remember several points as you use your EHR system in your practice in case you are chosen for an audit of your EHR Incentive Program payment.

Key Point # 1: Keep sufficient documentation of your patient encounters, including the supporting documentation for the criteria you choose to report as part of the attestation process and any other records that could be used to prove the encounter took place during the reporting period. An EHR "does not think" and it is important to add additional relevant information regarding the patient's problem during the visit in order to support what is being done. It is also helpful to keep records of any conversations you have with official resources like the EHR Incentive Program Information Center concerning questions about attestation.

Proper Coding and Cloning: Another important point a physician and his/ her office should remember refers to the



Figure 1. Physician Use of EHRs and their Capabilities. Source: http://www.cdc.gov/nchs/data/databriefs/db111.htm billing associated with EHR systems. Many systems provide suggested CPT and associated ICD 9 codes to assist with the billing process. However, it is important to remember that these are suggestions, not hard facts. The responsibility for proper coding rests with the physician and his office, not the EHR or the vendor that developed the system. "Upcoding" and "cloning" are two terms that have quickly become associated with issues surrounding EHR coding and present challenges to physicians when it comes to protecting themselves.

Cloning refers to an EHR system automatically copying and pasting notes from a previous patient encounter into a new documentation of examination, and when coupled with new information input into the note, could lead to the EHR suggesting a higher level of E/M exam. In any case, the physician, working with his staff, is ultimately responsible for ensuring correct coding and need to code based on 1995 or 1997 E/M coding guidelines. One way to help ensure correct coding is to work with the vendor to allow the prior information to be seen, but not "counted" as part of the visit. Speak with your vendor to see if your EHR system has this capability.

Key Point #2: As the physician, you must ensure that you review the information included in a note and the suggested associated E/M code and confirm the proper codes are reported.

You can review your contract with your vendor, but in many cases, vendors explicitly state they are not responsible for any coding submitted by a physician and it is the responsibility of the physician to make sure they are coding correctly.

Potential Liability Issues: Along with potential audits associated with the use of an EHR, physicians must also assess the potential personal and medical liability issues associated with the use of an EHR. Sensitive patient data is stored and transmitted via an EHR and it is essential you work to ensure this information is protected. Many EHRs meet the specified security criteria set by ONC, but it is important that you check with your vendor to verify your system meets the necessary security criteria and is up to date to protect against threats.

According to The Doctors Company, another issue physicians must be aware of is "alert fatigue." Many EHRs have the capability to alert the physician of different warnings including drug-drug interactions, drug allergies, or other designated alters. "Because of 'alert fatigue,' there is a danger that doctors may ignore, override, or disable alerts, warnings, reminders, and embedded practice guidelines. If it can be shown that following an alert or a guideline would have prevented an adverse patient event, the doctor may be found liable for failing to follow it."

Key Point #3: Work with your vendor and your attorney to understand your rights and responsibilities when it comes to potential medical and personal liability risks when using an EHR in your practice.

Resources to Help: The Academy does have resources designed to help you navigate the world of Meaningful Use and the policies that govern the program, which can be found on the Academy's EHR webpage at http://www.entnet.org/ Practice/ONC.cfm. Here you can find the Academy's comment letters and summaries, as well as details on the specific objectives and measures in meaningful use. The Academy continues to comment on current and future regulations based upon our members' needs and experiences.

If you have specific questions regarding your system or your potential liability, the Academy recommends contacting your vendor, consultant, or an attorney that can best help you with your specific and unique case. However, the Academy can direct you to several resources designed to help navigate the world of electronic health records and your practice.

Government Agency Resources

- The Agency for Healthcare Research and Quality (AHRQ) has developed a guide to reducing unintended consequences when using an EHR. http:// www.ucguide.org/index.html.
- The CMS EHR Incentive Program Information Center is a toll free hotline that helps answer all physician questions regarding EHRs. (888) 734-6433, TTY (888) 734-6563.
- CMS EHR Incentive Program criteria and information. http://cms.gov/ ehrincentiveprograms.
 Additional Resources
- Karen Zupko and the AAO-HNS provide workshops that can help you learn how to code properly and help protect against audits. http://www.entnet.org/ ConferencesAndEvents/codingworkshops.cfm.
- The Doctors Company, the largest medical malpractice insurer, has a useful page full of resources to navigate physician liability when it comes to EHRs. http://www.thedoctors.com/KnowledgeCenter/EHRandTelemedicine/index.htm.

For additional questions about electronic health records or meaningful use criteria, email Joe Cody, MA, health policy analyst at healthpolicy@entnet.org.

CMS Quality Reporting Initiatives Fact Sheets

This is a pivotal year for physicians as the Centers for Medicare & Medicaid Services (CMS) now begins to apply penalties across three of its quality initiatives. In 2015, physicians will be subject to financial penalties, known as payment adjustments, for the first time for the Electronic Health Record (EHR) Meaningful Use Incentive Program and Physician Quality Reporting System (PQRS). The 2015 EHR and PQRS penalties are based on participation and reporting in 2013. Penalties also increase for failing to participate and meet the e-Prescribing (eRx) Incentive Program reporting criteria in 2013. In order to help you understand the reporting requirements for these quality initiatives, the Academy has created one-page fact sheets for each of the CMS initiatives. These fact sheets include a brief overview of the program; provide information on how you and your practice can successfully meet the reporting criteria, earn incentives, avoid payment reductions; and direct you to additional resources to help you in 2013. For information on all of these programs, visit the Academy's CMS Quality Initiatives webpage at www.entnet.org/cmspenalties.

Long-Term 52-Week Safety Trial: In a 52-week placebo-controlled long-term safety trial in patients with PAR, 415 patients (128 males and 287 females, aged 12 to 74 years) were treated with QNASL Nasal Aerosol at a dose of 320 mcg once daily and 111 patients (44 males and 67 females, aged 12 to 67 years) were treated with placebo. Of the 415 patients treated with QNASL Nasal Aerosol, 219 patients were treated for 52 weeks and 196 patients were treated for 30 weeks. While most adverse events were similar in type and rate between the treatment groups, epistaxis occurred more frequently in patients who received QNASL Nasal Aerosol (45 out of 415, 11%) than in patients who received placebo (2 out of 111, 2%). Epistaxis also tended to be more severe in patients treated with QNASL Nasal Aerosol. In 45 reports of epistaxis in patients who received QNASL Nasal Aerosol, 27, 13, and 5 cases were of mild, moderate, and severe intensity, respectively, while the reports of epistaxis in patients who received placebo were of mild (1) and moderate (1) intensity. Seventeen patients treated with QNASL Nasal Aerosol experienced adverse reactions that led to withdrawal from the trial compared to 3 patients treated with placebo. There were 4 nasal erosions and 1 nasal septum ulceration which occurred in patients who received QNASL Nasal Aerosol, and no erosions or ulcerations noted in patients who received placebo. No patient experienced a nasal septum perforation during the trial.

6.2 Postmarketing Experience

In addition to adverse reactions reported from clinical trials for QNASL Nasal Aerosol, the following adverse events have been reported during use of other intranasal and inhaled formulations of beclomethasone dipropionate. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure. These events have been chosen for inclusion due to either their seriousness, frequency of reporting, or causal connection to beclomethasone dipropionate or a combination of these factors.

Intranasal beclomethasone dipropionate: Nasal septal perforation, glaucoma, cataracts, loss of taste and smell, and hypersensitivity reactions including anaphylaxis, angioedema, rash, and urticaria have been reported following intranasal administration of beclomethasone dipropionate.

<u>Inhaled beclomethasone dipropionate</u>: Hypersensitivity reactions, including anaphylaxis, angioedema, rash, urticaria, and bronchospasm have been reported following the oral inhalation of beclomethasone dipropionate.

7 DRUG INTERACTIONS

No drug interaction studies have been performed with QNASL Nasal Aerosol.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Teratogenic Effects: Pregnancy Category C

There are no adequate and well-controlled clinical trials in pregnant women treated with QNASL Nasal Aerosol. Beclomethasone dipropionate was teratogenic and embryocidal in the mouse and rabbit although these effects were not observed in rats. QNASL Nasal Aerosol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Experience with oral corticosteroids since their introduction in pharmacologic, as opposed to physiologic, doses suggests that rodents are more prone to teratogenic effects from corticosteroids than humans.

Beclomethasone dipropionate administered subcutaneously was teratogenic and embryocidal in the mouse and rabbit at doses approximately twice the maximum recommended human daily intranasal dose (MRHDID) in adults (on a mg/m² basis at maternal doses of 0.1 and 0.025 mg/kg/day in mice and rabbits, respectively). No teratogenicity or embryocidal effects were seen in rats at approximately 460 times MRHDID (in adults on a mg/m² basis at a maternal inhalation dose of 15 mg/kg/day).

<u>Non-teratogenic Effects</u>: Hypoadrenalism may occur in infants born of mothers receiving corticosteroids during pregnancy. Such infants should be carefully monitored.

8.3 Nursing Mothers

It is not known whether beclomethasone dipropionate is excreted in human breast milk. However, other corticosteroids have been detected in human breast milk and thus caution should be exercised when QNASL Nasal Aerosol is administered to a nursing mother.

8.4 Pediatric Use

The safety and effectiveness for seasonal and perennial allergic rhinitis in children 12 years of age and older have been established. Controlled clinical trials with QNASL Nasal Aerosol included 188 adolescent patients 12 to 17 years of age *[see Clinical Studies (14)]*. The safety and effectiveness of QNASL Nasal Aerosol in children younger than 12 years of age have not been established.

Controlled clinical trials have shown that intranasal corticosteroids may cause a reduction in growth velocity in pediatric patients. This effect has been observed in the absence of laboratory evidence of hypothalamic-pituitary-adrenal (HPA) axis suppression, suggesting that growth velocity is a more sensitive indicator of systemic corticosteroid exposure in pediatric patients than some commonly used tests of HPA-axis function. The long-term effects of reduction in growth velocity associated with intranasal corticosteroids, including the impact on final adult height, are unknown. The potential for "catch-up" growth following discontinuation of treatment with intranasal corticosteroids has not been adequately studied. The growth of pediatric patients receiving intranasal corticosteroids, including QNASL Nasal Aerosol, should be monitored routinely (e.g., via stadiometry). A 12-month, randomized, controlled clinical trial evaluated the effects of

A 12-month, randomized, controlled clinical trial evaluated the effects of QVAR[®], an orally inhaled HFA beclomethasone dipropionate product, without spacer versus chlorofluorocarbon-propelled (CFC) beclomethasone dipropionate with large volume spacer on growth in children with asthma ages 5 to 11 years. A total of 520 patients were enrolled, of whom 394 received HFA-beclomethasone dipropionate (100 to 400 mcg/day ex-valve) and 126 received CFC-beclomethasone dipropionate (200 to 800 mcg/day ex-valve). When comparing results at month 12 to baseline, the mean growth velocity in children treated with HFA-beclomethasone dipropionate with CFC-beclomethasone dipropionate via large volume spacer. The potential growth effects of prolonged treatment should be weighed against the clinical benefits obtained and the risks/benefits of treatment alternatives.

The potential for QNASL Nasal Aerosol to cause reduction in growth velocity in susceptible patients or when given at higher than recommended dosages cannot be ruled out.

8.5 Geriatric Use

Clinical trials of QNASL Nasal Aerosol did not include sufficient numbers of subjects aged 65 years and older to determine whether they responded differently than younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, administration to elderly patients should be cautious, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

10 OVERDOSAGE

Chronic overdosage may result in signs/symptoms of hypercorticism [see Warnings and Precautions (5.5)]. There are no data available on the effects of acute or chronic overdosage with QNASL Nasal Aerosol.



Teva Respiratory, LLC Horsham, PA 19044 USA

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Manufactured for Teva Respiratory, LLC Horsham, PA 19044 By: 3M Drug Delivery Systems Northridge, CA 91324



(beclomethasone dipropionate) Nasal Aerosol

QNA0612BP-1

Rev. 06/12





Successfully Navigating the Centers for Medicare & Medicaid (CMS) Electronic Health Records Incentive Program

What is the EHR Incentive Program? =

The Electronic Health Records (EHR) Incentive Program is a CMS initiative designed to facilitate the use of EHRs in clinical settings. Eligible professionals (EPs), hospitals, and critical access hospitals that demonstrate meaningful use of EHRs are currently eligible for incentive payments and subject to penalties for not successfully meeting Meaningful Use starting in 2015. The program has 3 Stages with Stage 1 currently under way, Stage 2 set for 2014, and Stage 3 set to begin in 2016.

EHR/Meaningful Use Incentives and Penalties in 2013 and Beyond

	2013	2014	2015	2016	2017
Incentive Amount	\$8K-\$15k	\$4K-\$12k	\$2K-\$8K	\$2K-\$4K	N/A
Penalty Amount	N/A	N/A	-1% (based on 2013 reporting)	-2% (based on 2014 reporting)	-3% (based on 2015 reporting)

How to Earn Incentive Payments

- 1. Determine if you are an eligible professional for the program and register for the program at https://ehrincentives.cms.gov
- Purchase an Office of the National Coordinator (ONC) Health IT Certified EHR System. A list of Certified EHRs can be found at http://oncchpl.force.com/ehrcert
- 3. Report 20 out of 25 Core and Menu Objectives and 6 out of 44 Clinical Quality Measures (CQMs)
 - a. EPs are required to report 15 Core Objectives and 10 possible Menu Objectives. A detailed list can be found at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads//EP-MU-TOC.pdf
 - b. EPs are required to report 3 Core or Alternate Core CQMs and 3 additional CQMs chosen from a list that can be found at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CQM_EPs_2012_02_02.pdf
- 4. In Stage 1, there are two different reporting periods depending on how long you have participated in the program
 - a. For your first year, report data from any continuous 90-day period during the calendar year (any 90 continuous days from January 1st to December 31st).
 - b. From year 2 forward, report for the full Calendar year (Jan. 1 to Dec. 31, 2013 for example).

Note: EPs cannot earn incentives in both the EHR Meaningful Use and Electronic Prescribing Incentive Programs

How to Avoid Penalties

- 1. EPs must meet the Meaningful Use criteria above (20 Core and Menu Objectives and 6 Clinical Quality Measures over the reporting period) or;
- 2. Qualify for an exemption for 2013 reporting requirements. Exemptions are granted on an annual basis and must be applied for annually.

EHR Program Changes for 2013

- New Alternative Measure for Computerized Physician Order Entry (CPOE) Core Objective
- Change in Measure for Record and Chart Vital Signs Core Objective
- Elimination of CQM reporting Objective. HOWEVER, CQMs must still be reported to successfully attest to meaningful use
- Electronic Exchange of Key Clinical Information is no longer required
- All Stage 2 public health objectives require at least one test of EHR capability to send data to public health agencies

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage1ChangesTipsheet.pdf




Successfully Navigating the Centers for Medicare Medicaid (CMS) Electronic Prescribing Incentive Program

What Is the eRx Incentive Program?

The Electronic Prescribing (eRx) Incentive Program is a CMS reporting program that uses a combination of incentive payments and payment adjustments (penalties) to encourage electronic prescribing by eligible professionals. The program provides an incentive payment to practices with eligible professionals (identified on claims by their National Provider Identifier [NPI] and Tax Identification Number [TIN]) who successfully e-prescribe for covered Medicare Physician Fee Service Schedule (MPFS) services for Medicare Part B Fee-for-Service (FFS) beneficiaries.

eRx Incentives and Penalties in 2013 and Beyond

	2013	2014	2015
Incentive Amount	.5%	N/A	N/A
Penalty Amount	-2%	-2%	TBD in future rule making

How to Earn Incentive Payment (.5% in 2014, based on 2013 reporting)

- 1. Determine if you are an eligible professional and able to participate. Ten percent of an eligible professional's Medicare Part B PFS charges must be comprised of specific codes in the denominator of the measure. For a list of the codes, see the Academy's eRx page at http://www.entnet.org/Practice/MedicareERxFactSheet.cfm.
- 2. Adopt a qualified e-prescribing system, whether it is stand alone or an electronic health record (EHR) with e-prescribing capabilities. Note that an EHR system must be ONC certified.
- 3. Determine your method of reporting and report the eRx measure (G8553) for a minimum of 25 patients during the Incentive Payment reporting period (Jan. 1, 2013- Dec. 31, 2013). Groups have higher reporting thresholds dependent on group size. You can report via three methods:
 - a. Claims-based reporting of the eRx measure. Report G-code (G8553) for 2013 eRx events.
 - b. Registry-based reporting using a qualified registry to submit 2013 data to CMS during the first quarter of 2014.
 - c. EHR-based reporting using a qualified EHR product, submitting 2013 data to CMS during the first quarter of 2014.

Note: EPs cannot earn incentives in both the EHR Meaningful Use and Electronic Prescribing Incentive Programs

How to Avoid Penalties

- 1. Qualify for an Incentive Payment
- 2. Report G-code (G8553) on a minimum of 10 unique visits from January 1, 2013 through June 30, 2013.
- 3. Receive an exemption from 2014 penalties. Exemptions must be applied for by June 30th, 2013 and include:
 - a. Practice in a rural area without adequate high-speed internet access
 - b. Practice in a location without enough available pharmacies for e-prescribing
 - c. Physicians who are unable to electronically prescribe due to local, State, or Federal law or Regulation
 - d. Physicians who infrequently prescribe
 - e. Insufficient opportunities to report the e-prescribing measure due to program limitations
 - f. Successfully achieve Meaningful Use in the CMS Electronic Health Record (EHR) Meaningful Use Incentive Program
 - g. Demonstrate intent to participate in the EHR Incentive Program for the first time by registering for the program and adopting certified EHR technology.

EHR Program Changes for 2013

- New Exemptions from penalties based upon EHR Incentive Program participation (detailed above)
- For the first time, Eligible professionals and group practices participating in the eRx Group Practice Reporting Option (GPRO) will have the opportunity to request an informal review of their 2013 eRx Incentive Program incentive payment and/or subjectivity to the 2014 eRx payment adjustment to ensure accuracy
- The 2013 eRx Incentive Program denominator changed with new encounter codes for reporting
- Change in GPRO reporting thresholds dependent on group size. Details on thresholds found at http://www.entnet.org/Practice/MedicareERxFactSheet.cfm





Successfully Navigating the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting System (PQRS)

What is PQRS? =

PQRS is a CMS reporting program that uses a combination of incentive payments and penalties (payment adjustments) to promote reporting of quality information by physicians and other health professionals. Prior to 2010 the program was known as the Physician Quality Reporting Initiative (PQRI).

PQRS Incentives and Penalties in 2013 and Beyond =

	2013	2014	2015	2016
Incentive Amount	0.5%	0.5%		
Penalty Amount			-1.5% (based on 2013 reporting)	-2% (based on 2014 reporting)

How to Earn an Incentive Payment in 2013

- 1. Decide whether to report as an individual or as a group practice (group reporting is now available to practices with 2 or more eligible professionals)
- 2. Determine which reporting mechanism you will use to report, in 2013 there are 3 options:
 - a. Claims-based reporting
 - b. Registry-based reporting, such as PQRI wizard: https://aaohns.pqriwizard.com/default.aspx
 - c. EHR direct vendor or EHR data submission vendor reporting
- 3. Decide whether to report on individual quality measures (a minimum of 3 individual measures must be reported) or a measures group
- 4. Choose to report over a 12 month (Jan. 1 Dec. 31) or 6 month (Jul. 1 Dec. 31) period

Note: The reporting requirements to become eligible for an incentive differ by the reporting mechanism and type of measures selected (individual measures versus a measures group). 2013 reporting requirements are available at http://www.entnet.org/pqrs

How to Avoid the 2015 Penalty

- 1. Earn a 2013 PQRS incentive payment (as outlined above)
- 2. Submit data to CMS on 1 individual measure*
- 3. Self-nominate for administrative claims reporting*

* Note: CMS highlighted in the 2013 Medicare Physician Fee Schedule Final rule that the reduced reporting requirements to avoid the 2015 penalty will only be available this year.

PQRS Changes for 2013

- 2013 is the first reporting year that is tied to future penalties (payment adjustments)
- The group practice reporting option has been expanded to practices with 2 or more eligible professionals
- CMS have incorporated additional reporting options to avoid the 2015 penalty (payment adjustment)
- Two individual quality measures applicable to otolaryngologists have been removed from the program 'Measure #124: Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)' and 'Measure #92: Acute Otitis Externa (AOE): Pain Assessment'.

Medicare Quality Penalties: A Wizard Can Help

Rahul K. Shah, MD George Washington University School of Medicine Children's National Medical Center, Washington, DC

his column has afforded a unique opportunity during the past five years to help escalate patient safety and quality improvement issues that are highlighted in the media, within our Academy, and anecdotally from our practices. Rarely do we delve into politically sensitive or potentially explosive issues. However, the recent data on the Physician Quality Reporting System (PQRS) has some a bit concerned about the readiness of our Academy members to proactively engage in reporting.

Fortunately, the Academy has been ahead of the game for PQRS reporting and has even partnered to provide our membership an extremely easy portal/method to track and report the requisite metrics called PQRI*wizard* (https://aaohns.pqriwizard. com/). Our Academy staff members, Jean Brereton and Peter Robertson, have been monitoring the national landscape *vis-à-vis* PQRS and have made efforts to let our membership know about this program.

PQRS is a program from the Centers for Medicare & Medicaid Services (CMS) that began in 2007 and initially purported to be a voluntary program that provided

> PQRS is a program from the Centers for Medicare & Medicaid Services (CMS) that began in 2007 and initially purported to be a voluntary program that provided financial incentives for reporting on specific quality measures.

financial incentives for reporting on specific quality measures. Recent data demonstrates that for individual physicians the incentive payments are around \$2,000, and for practices it is about \$20,000.¹ I stress the word "initially" in the above statement as now it is clear that the time for incentives is passing.

are not being aggressive in putting in place hard-wired pathways to ensure proper data collection. That may suffice for now, but many of us fear that this is just the beginning. If there is proof-of-principle that the payment adjustments markedly increase reporting on quality metrics, then I am sure all insurers will be forced to collect similar

Fortunately, the Academy has been ahead of the game for PQRS reporting and has even partnered to provide our membership an extremely easy portal/method to track and report the requisite metrics called PQRI*wizard* (https://aaohns.pqriwizard.com/).

CMS has stated that in 2015, there will be payment adjustments—read: penalties—for not properly reporting the mandatory quality metrics. The time has now come! The 1.5 percent noncompliance penalty will not be put in place until 2015. However, CMS is basing this penalty on data collected in 2013!

Therefore, Academy members must start reporting the PQRS metrics to CMS now if they do not want to be penalized in 2015. To this end, the Academy is an excellent resource for helping the membership learn about, collect, and report the pertinent PQRS metrics.² The tool, PQRI*wizard*, helps accomplish the tedious part of the data collection and reporting for practitioners and practices.

It is no surprise that to encourage compliance, CMS raises the payment adjustment to two percent in 2016. CMS has been consistent in following the stated plan to provide support and incentives in the beginning so that practitioners and practices could take a few years to integrate reporting into their practice flow. CMS has always noted that in the future the reporting of PQRS metrics would be mandatory with payment adjustments for noncompliance.

Some of our Academy members do not have a large proportion of Medicare patients in their patient panels and hence data with similar adjustments.

Our Academy has tremendous resources for the PQRS program and has tools available to help. I strongly encourage our membership to spend a bit of time on these items to understand what is being asked of us, and what we will potentially be penalized for not reporting. Furthermore, for those practitioners and physicians attempting to avert the 2015 payment adjustment, it is imperative to begin reporting and collecting the data this year—in 2013—for this is the year that the 2015 adjustments will be based upon.

We encourage members to write us with any topic of interest and we will try to research and discuss the issue. Members' names are published only after they have been contacted directly by Academy staff and have given consent to the use of their names. Please email the Academy at qualityimprovement@entnet.org to engage us in a patient safety and quality discussion that is pertinent to your practice.

References

- Most doctors headed for penalty over Medicare quality reporting. http://www.amaassn.org/amednews/2012/05/28/gv110528. htm, accessed 1/30/13.
- 2. http://www.entnet.org/pqrs.







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For more information on support opportunities, please contact:

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Coding and Reimbursement Strategies: Using an Unlisted Code for Endoscopic Skull Base Surgery

Kim Pollock, RN, MBA, CPC Mary LeGrand, RN, MA, CCS-P, CPC

he American Medical Association's Current Procedural Terminology® (CPT) codes for reporting medical services and procedures performed by physicians must be used to bill services to third party payers. The contemporary practice of medicine is occasionally ahead of the CPT code system and an accurate code may not always exist for the procedure performed; this is true for reporting most endoscopic/ endonasal skull base surgery procedures.

Coding Issues

Only one CPT code exists for an endoscopic skull base procedure—62165, *Neuroendoscopy, intracranial; with excision of a pituitary tumor, transnasal, or trans-sphenoidal approach.* Unlike the skull base surgery codes that include separate codes for the approach and definitive procedure, CPT 62165 includes the approach, tumor resection, and closure. Modifier 62 (two surgeons) is appended to 62165 when performed as co-surgery involving the otolaryngologist (ORL) and neurosurgeon (NS) to show that neither surgeon performed the entire procedure code.

The existing open (involving a skin incision) skull base surgery CPT codes were introduced to the CPT code system in 1994. Endonasal/endoscopic skull base surgery is relatively new and performed in a limited number of organizations. Therefore, endonasal/endoscopic skull base procedures, except the endoscopic resection of a pituitary tumor (62165), do not have a CPT code. Both the AAO-HNS and the American Association of Neurological Surgeons agree it is not accurate to use the existing skull base surgery CPT codes for endonasal/endoscopic procedures because the existing codes describe an open procedure involving skin incision(s).

Current Coding Landscape

Many otolaryngology and neurosurgery practices have implemented a successful coding and reimbursement strategy for performing endoscopic skull base surgery procedures together. We have found that many payers fail to recognize, and appropriately reimburse, claims where both surgeons report the same unlisted code with modifier 62 (e.g., 64999-62). Also, CPT guidelines state it is not appropriate to append a modifier to an unlisted code because an unlisted code does not describe a specific procedure.

Because each surgeon is performing his or her own separate procedure in endoscopic/endonasal skull base surgery, much like in the use of the existing skull base surgery codes, we recommend each surgeon report his or her own unlisted CPT code (ORL–31299, NS–64999). It is not accurate to report individual component codes (e.g., endoscopic sinus surgery, septoplasty) instead of an unlisted code for endoscopic skull base surgery as this is not in line with CPT coding guidelines.

Using an Unlisted Code

Each unlisted CPT code is used to describe the actual work by each surgeon. Consider an endoscopic transnasal approach to the anterior cranial fossa, intradural resection of a clival chordoma, with dura repair and septal flap closure. In this scenario, the ORL assists the NS by holding the endoscope and vice versa.

The otolaryngologist reports 31299 (Unlisted procedure, accessory sinuses) for his or her portion of the procedure and this code encompasses the ORL's work of the transnasal approach, entering the skull base, but not the dura, assisting the neurosurgeon during the dural opening and tumor resection, and then performing the closure using a local flap.

Use a "base" or similar existing comparison CPT code to determine the ORL's fee for 31299. For example, the base code might be 61580 (*Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration*) for the above example of the clival chordoma endoscopic resection. The ORL fee for 31299 would include his or her assistant surgeon activity (modifier 80 or 82) on the NS's base code.

Repair of the Dura/Closure

Closure of the dura is included in the unlisted procedure code reported just as it is part of the usual skull base surgery definitive procedure codes (e.g., 61601). Do not use codes such as 61618 or 61619 (secondary repair of cerebrospinal fluid (CSF) leak codes) as a comparison or base code for the unlisted code billed. A return to the operating room subsequent to the initial procedure, for repair of a CSF leak, may be separately reported.

Additionally, CPT guidelines include surgical wound closure in the open resection/excision definitive procedure skull base code. However, if graft material is harvested through a separate surgical exposure, then a separate graft harvest code may be reported.

It is not appropriate to report 15750 (*Flap; neurovascular pedicle*) for a nasolabial flap. CPT says the following about 15750: "This code includes not only skin, but also a functional motor or sensory nerve(s). The flap serves to reinnervate a damaged portion of the body dependent on touch or movement (e.g., thumb)." The nasolabial flap is created through the same surgical exposure as the primary procedure so it would be included in the primary procedure code.

Postoperative Care

There is no defined postoperative global period for an unlisted code; therefore, the fee for the unlisted code may reflect a zero-day postoperative global period. Doing so allows the surgeon to separately report all postoperative follow-up care in the hospital, and in the office, including a sinus debridement (31237) and/or nasal endoscopy (31231). The fee for any comparison or base code(s) include a 90-day global period, therefore, the surgeon may want to decrease his/her fee for the unlisted code. Alternatively, the surgeon may set his/her fee for the unlisted code to reflect a 90-day postoperative global period similar to the open skull base code(s) used as the comparison or base code(s).

Reimbursement Issues

Many payers do not have a strategy for reimbursing unlisted CPT codes. KarenZupko & Associates, Inc., recommends the following actions to ensure optimal reimbursement for these services.

- Make sure your managed care contracts include a clause requiring payers to reimburse a specific percentage of your billed charge since unlisted codes do not have an assigned Medicare relative value unit (RVU) or payment amount.
- Make an appointment for both specialty surgeon(s) to meet with the medical directors and provider relations representatives (together at the same meeting) of your major payers and present a professional PowerPoint talk with a couple

of patient case studies. Also, show how performing the procedure endoscopically results in lower cost and higher quality of care.

- Use the letter that follows as one of the following tools: 1) a written prior authorization letter as part of the approval process prior to surgery, 2) a cover letter with the ORL claim submission, or 3) as an appeal letter for a claim denial. Customize the letter to meet your specific need and patient case.
- It is beneficial to bill and collect for both specialties out of a separate, combined billing area or provider listing in the practice management system when both specialties are in the same practice. This allows separation of these combined specialty cases resulting in easier data analysis. For example, while Medicare may not provide significant additional payment for an unlisted code, we have

found that other payers do. One can easily calculate the average payment per case if these services are billed from a separate billing area or provider listing. The funds can also be more easily divided in a manner equitable to both specialties if desired.

Conclusion

Advancements in technology and clinical care are crucial in medicine, although the associated billing and reimbursement practicalities may be challenging. A strategy for accurate coding and optimal reimbursement is critical for otolaryngologists and neurosurgeons who perform endoscopic skull base surgery.

Kim Pollock and Mary LeGrand are consultants with KarenZupko & Associates, Inc., a Chicago-based physician practice management consulting company. Both are instructors for the AAO-HNSF/KZA coding and reimbursement workshops.

Sample Prior Authorization, Cover Letter, or Appeal Letter for the Otolaryngologist's Use of an Unlisted CPT Code for Endoscopic/Endonasal Skull Base Surgery

To Whom It May Concern:

Attached is a copy of Dr. _____'s operative note and CMS 1500 claim form to support the use of an unlisted Current Procedural Terminology® (CPT) code for the procedure(s) performed. There are no CPT codes for endoscopic skull base surgery; therefore, I used CPT 31299 (unlisted procedure, nervous system) for my endoscopic definitive procedure of the skull base tumor resection and closure.

The CPT guidelines instruct physicians not to select a CPT code that merely approximates the service provided. Additionally, CPT guidelines state if no such procedure or service exists, then the appropriate unlisted procedure or service code is reported. We are following CPT guidelines by reporting an unlisted CPT code, 31299, because the current skull base CPT codes do not describe an endoscopic/endonasal procedure.

The following table, below left, shows the procedures performed and represented by the CPT code billed and the surgeon's fee using the appropriate unlisted code. The table below on the right shows a comparison to the current "open" skull base surgery CPT code and our associated fee so you will understand how we derived our charge for this patient's procedure.

[Add the following statement if the fee reflects a zero-day postoperative global period: Please note that there is no postoperative global period assigned to unlisted CPT codes; therefore, I will be separately reporting all necessary follow-up care including hospital care (9923x), office visits (9921x), endoscopic sinus debridements (31237), and nasal endoscopy (31231).]

[Add the following statement if the fee reflects a 90-day postoperative global period: Please note that I have included in the fee all postoperative care for 90 days as is included in the comparative base open CPT code(s) listed above. This includes at least three hospital days and two office visits with endoscopic sinus debridements performed bilaterally (31237-50).]

Procedure Performed/Unlisted CPT Code/Our Fee	Comparative Base Open CPT Code(s)/Our Fee	
CPT 31299 Unlisted procedure, nervous system (List name of endoscopic procedure here as written by the physician on the operative note)	CPT (list the codes, descriptions, and fees for the codes used in comparison)	
Fee: \$	Fee: \$	

Thank you in advance for kindly processing this claim in an expeditious and appropriate manner.

Sincerely, Dr. Otolaryngologist

CPT Code Changes: Implantation of Biologic Implant +15777

or CY 2013, the Current Procedural Terminology® (CPT) Editorial Panel has modified the descriptor for add-on code +15777 and has limited this code's use to biologic implants placed into breast and/or trunk sites only. The new text is highlighted and underlined, and the new descriptor and corresponding parentheticals are noted in the following box.

The highlighted text notes changes that directly affect otolaryngologyhead and neck surgeons. Providers implanting biologic implants for soft tissue reinforcement in areas such as the head or neck (such as implantation of Alloderm® into a parotidectomy wound bed) are now instructed to use the unlisted code CPT 17999 to report these procedures. Members should keep in mind that the unlisted code is not an add-on code, as is +15777, which was previously reported. This means reimbursement for the unlisted code (17999) may be subject to a multiple procedure payment reduction.

As a reminder, unlisted codes do not have specific Medicare payment associated with them and are subject to the approval of local Medicare Administrator Contractors (MAC). Members should work directly with their local MAC and third party payers to determine what reimbursement, if any, will be assigned to unlisted codes when supported with

For implantation of biologic implants for soft tissue reinforcement in tissues other than breast and trunk, use 17999

+15777

- Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (i.e., breast, trunk) (List separately in addition to code for primary procedure.)
- (For implantation of biologic implants for soft tissue reinforcement in tissues other than breast and trunk, use 17999)
- (For bilateral breast procedure, report 15777 with modifier 50.)
- (The supply of biologic implant should be reported separately in conjunction with 15777.)

the necessary medical and diagnostic documentation.

Members seeking more information should email the Academy health policy team at healthpolicy@entnet.org.

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Student (Daily Price):\$100.00
Workshops (April 26th)\$100.00 per workshop

Housing We have negotiated special discounted rates for our attendees. To make online discounted reservations, please view the available links on our registration page. Thank you! **The Third Annual ENT for the PA-C** conference is co-sponsored by the American Academy of Otolaryngology–Head & Neck Surgery Foundation (AAO-HNSF) and the Society of Physician Assistants in Otorhinolaryngology/Head & Neck Surgery (SPAO-HNS). This continuing medical education activity is specifically designed for physician assistants, nurse practitioners and medical professionals working or interested in otolaryngology.

The course is organized to provide attendees with an excellent networking opportunity. Workshops are designed to maximize hands-on learning with concise content and small group settings. This is also the ideal setting to meet, network, and socialize with like-mind-ed professionals from across the country.

We look forward to seeing you in New York!



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Professional Development Gap Analysis and Needs Assessment Initiative Under Way

Sonya Malekzadeh, MD AAO-HNSF Coordinator for Education

he AAO-HNS/F Board of Directors' 2013 Strategic Plan calls for a robust system to evaluate the activities and processes of the AAO-HNS Foundation's lifelong learning and continuing professional development program.

The Foundation unit has embarked on a yearlong initiative to seek input from stakeholders on member education and performance improvement gaps and needs. Education committee members, the BOG, and AAO-HNS members will be queried through surveys, SWOT analyses, and focus groups. Current program evaluations, quality and safety data, and literature reviews will also be included in this systematic and multifaceted process. This critical feedback will be used to direct decisions on types of activities, determine interventions, and guide program development.

The needs assessment and gap analysis process must be constant and not episodic. This initiative is intended to provide a foundation and planning framework for frequent evaluation of members' professional development needs. Building on the principles of lifelong learning while also mindful of opportunities for improvement, we will strive to maintain consistency and quality in the evaluation and implementation of education processes and outcomes.

The Initiative includes seven phases:

Phase 1: Education Committee Member Survey and SWOT Analysis

A comprehensive survey and SWOT analysis has been distributed to the eight specialty education committees. Each member is engaged in education planning and development, and thus has an intimate knowledge of the education processes and programs. As education leaders, these individuals are uniquely positioned to examine the internal education-related strengths and weaknesses as well as the external education-related opportunities and threats facing the Foundation.

Phase 2: Analyze Existing Data

Data on member participation, specific product usage, and evaluation of current education activities will be collected. Performance gaps will be identified through the Foundation's research and quality data, a review of pertinent scientific literature, national registry data, and other health assessment resources.

Phase 3: Education Product Survey

Foundation staff will survey individuals who currently participate in Foundation education activities. These include the Home Study Course and Patient Management Perspectives subscribers, online course participants, and Coding Workshop attendees. This survey will assess their opinions on the positive and negative aspects of each activity and determine venues by which the Foundation can improve upon these resources.

The needs assessment and gap analysis process must be constant and not episodic. This initiative is intended to provide a foundation and planning framework for frequent evaluation of members' professional development needs.

Phase 4: Membership Education Survey

The entire Academy membership will be queried to assess perceived practice gaps and education needs. This broad survey will examine the Foundation education activities on numerous levels and serve to engage members in lifelong learning.

Phase 5: Focus Groups

Focus groups will be assembled to assess the specific learning needs of each of our target audiences. A Board of Governors focus group meeting is scheduled for spring 2013.

Phase 6: Analysis and Reporting

AAO-HNSF staff and education leadership will work together on analysis and interpretation of the data. A summary report of the yearlong initiative will be prepared and presented to the Board of Directors at the 2013 Annual Meeting & OTO EXPOSM in Vancouver, BC, Canada.

Phase 7: Planning and Implementation

Gathering appropriate data will support the allocation of funds and resources toward planning feasible and effective programs. Education activities will be prioritized, developed, and implemented with the specific intent of closing practice gaps and meeting the learning needs of our members.

The gap analysis and needs assessment initiative will provide the Foundation with critical information and data to monitor, evaluate, and plan education activities. I urge you to participate in the forthcoming surveys and focus groups designed to measure the impact and effectiveness of our learning activities and processes. Your opinions will be used to modify current activities, enhance learning experiences, and develop outcomes measures that contribute to the professional development of otolaryngologists and quality patient care. Please take advantage of this unique opportunity to shape and direct the future of our specialty's education programming.

SAVE THE DATE! AAO-HNSF ANNUAL MEETING & OTO EXPO SEPTEMBER 29-OCTOBER 2, 2013

VANCOUVER, BC, CANADA

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- Scientific Program (Orals and Posters) Faculty Confirmed: April 2013

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In planning your trip to Vancouver this September, consider these options:





Outdoor Activities

Outside is where you'll find the heart and soul of the West Coast. Breathtaking scenery. Untouched wilderness. Wide open spaces. Fresh air and crystal water. Take part in Vancouver outdoor activities such as:

- Golfing
- Hiking on Vancouver's North Shore
- Ocean kayaking
- River rafting
- Salmon fishing
- Walk through rainforests

Shopping

As a cosmopolitan, coastal city, Vancouver's style ranges from haute couture to cozy flannels and fleece. Shopping in Vancouver offers this same diverse range with high fashion boutiques, designer labels, accessory and jewelry stores, and extensive shop-'til-you-drop malls.

There are distinctive areas all around Vancouver for clothing, art, ceramics, furniture, and much more waiting for you to discover. For some great shopping areas in Vancouver, visit:

- Burnaby—Metropolis at Metrotown
- Chinatown
- Commercial Drive
- Downtown and Gastown
- Granville Street

- Granville Island Market
- Robson Street
- Yaletown

First Nations Heritage

Vancouver is also rich with native heritage and there are many opportunities to learn about this unique and inspiring culture. A few outstanding First Nations' activities, tours, and culinary options include:

- Sweat lodge
- Heritage Tour (atop Grouse Mountain)
- First Nations nature tour
- Listel Hotel—Native Art/Museum
- Museum of Anthropology at UBC
- Native food catering, Major the Gourmet
- Native canoe, Takaya Tours
- Executives without ties (Squamish Tribe)

Pre- and Post-Conference Tours

Enhance your Vancouver meeting and convention experience by taking advantage of the incredible pre- and post-opportunities Vancouver and British Columbia have to offer. A few suggestions for outstanding pre- and post-travel options:

- Whistler
- Victoria and Vancouver Island
- Nanaimo
- Vancouver—Alaska cruise (check out website www.entnet.org/annual_meeting for AAO-HNSF attendees special promotional discounts)
- Okanagan Valley
- Rocky Mountains

Stay tuned for next month's issue of the *Bulletin*, which will contain the 2013 Annual Meeting & OTO EXPO Preliminary Program featuring the entire instruction course and miniseminar program. We invite you to come to the AAO-HNSF 2013 Annual Meeting & OTO EXPO in Vancouver, BC, to experience everything the annual meeting and Vancouver have to offer you. Registration and housing will open in May 2013.

Travel to Canada

Will you be one of the convention attendees traveling from the U.S. or internationally into Canada? If so, you should know that thousands of people visit Canada to attend conferences every year. We invite you to visit the following link to the Citizenship and Immigration Canada website (www.cic.gc.ca) to key important information for event attendees. We recommend that you bookmark this website and refer to it often as a resource to help you avoid problems that can affect your travel plans. The CIC website will help you to:

- Determine your Eligibility—Find out if you qualify as a business visitor.
- Apply—Before you plan your visit, you should find out if you need a visa to enter Canada. If you do not need a visa to enter Canada, you will still need to meet some specific requirements. If you do need a visa, find out how to apply.
- Check Processing Times—Most applications for visitor visas (temporary resident visas) are processed within a few weeks or less. Processing times vary depending on the visa office.
- After You Apply: Get Next Steps—Find out what you should do after you apply for a visitor visa.
- Prepare for Arrival—Be prepared and know what to expect when you arrive in Canada.
- Extend your Visa—To extend your stay in Canada, you should apply 30 days before your status expires.
- Bring a Guest to Canada—You can avoid problems or delays when you bring your foreign business guests to Canada by following certain guidelines.

Final Preparation for Your Trip to Vancouver

Before catching your flight to Canada, contact your local cell phone carrier to learn about special pricing plans for calls, text messaging, and Internet usage outside your home country. If you use a smartphone, ask your carrier about certain settings such as "airplane mode" that may help you save money on usage.

Take Note: Roaming charges and data plan fees for cell phones (especially smart phones like the iPhone or the Android) and tablets like the iPad can be costly, with prices spiking as high as several dollars per minute. Below are links to some popular carriers' international coverage plans:

- Verizon Wireless–www. verizon.com
- AT&T–www.att.com
- Sprint–www.sprint.com
- T-Mobile–www.t-mobile. com
- Boost Mobile–www.boostmobile.com
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4th International Coalition for Global Hearing Health Conference Set

or a fourth consecutive year, multiple disciplines worldwide will confer on global concerns about hearing healthcare at the 4th Coalition for Global Hearing Health Conference, which will take place May 3-4 at Vanderbilt University in Nashville, TN.

Past conferences have been hosted by such world-recognized facilities as EduPlex, South Africa (2012); House Ear Institute, Los Angeles (2011); and the American Academy of Otolaryngology—Head and Neck Surgery, Washington, DC (2010).

The purpose of each annual conference is to provide an opportunity for otolaryngologists, audiologists, deaf educators, speech pathologists, policy makers, philanthropic leaders, deaf and hard-of-hearing individuals and families to work together to raise awareness of vital issues relative to hearing health in the developing world. Presentation topics will focus on: advocacy and media; education of professionals in underserved regions; empowering families and communities; harnessing technology; and ensuring best practices.

Conference co-organizers, **James E. Saunders, MD,** of Dartmouth Hitchcock Medical, and Jackie L. Clark, PhD, of the University of Texas at Dallas, have long-established roots on the international arenas as Humanitarian Committee chairs within their professional organizations, the American Academy of Otolaryngology-Head Neck Surgery Foundation and the International Society of Audiology, respectively.

To learn more about upcoming or past conferences, visit http://coalitionforglobalhearinghealth.org.

The purpose of each annual conference is to provide an opportunity for otolaryngologists, audiologists, deaf educators, speech pathologists, policy makers, philanthropic leaders, deaf and hard-ofhearing individuals and families to work together to raise awareness of vital issues relative to hearing health in the developing world.

Last Chance to Book for Dr. K.J. Lee's 2013 China Tour

May 1 is the deadline to book for Dr. K.J. Lee's tour of China, June 5-16. It starts following the IFOS World Congress in Seoul, South Korea, and ends at the World Chinese ENT Academy Congress in Hong Kong.

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- Hong Kong

To reserve today, call Donna Dalnekoff at 1-203-772-0060 or 1-800-243-1806, or email Donna.Dalnekoff@ATPI.com to do your booking. Questions? Contact Dr. K.J. Lee: 1-203-777-4005 or kjleemd@aol.com.



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Please visit www.migraineequivalent.org for details and application



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– Guest **S**peakers –

George T. Hashisaki, M.D. Associate Professor Department of Otolaryngology – HNS University of Virginia Health Systems – Charlottesville, VA

Robert C. Kern, M.D. Professor and Chairman Department of Otolaryngology – HNS Northwestern Feinberg School of Medicine – Chicago, IL

Gregory Postma, M.D.

Professor, Department of Otolaryngology Director, MCG Center for Voice & Swallowing Disorders Georgia Health Science Medical Center – Augusta, GA

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Emory University School of Medicine Department of Otolaryngology – Head and Neck Surgery

The Division of Head and Neck Surgery in the Department of Otolaryngology – Head and Neck Surgery at Emory University in Atlanta, Georgia seeks to add a fellowship-trained Head and Neck/ Microvascular surgeon, at the rank of Assistant Professor. The ideal candidate would also have experience with trans-oral robotic surgery (TORS). Duties will include resident and fellow level teaching and a clinical practice primarily involving mucosal tumors of the upper aerodigestive tract as well as a healthy free tissue reconstruction component. The position also includes a part-time VA component.

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Interested applicants should forward letters of inquiry and curriculum vitae to: Mark W. El-Deiry, MD, FACS Assistant Professor and Chief of Head and Neck Surgery Department of Otolaryngology – Head & Neck Surgery 550 Peachtree Street, Medical Office Tower, Suite 1135 Atlanta, Georgia 30308 or fax to (404) 778-2109 Email: meldeir@emory.edu An Equal Opportunity / Affirmative Action Employer. Qualified minority and female applicants are encouraged to apply. EOP # 34944BR

The University of Kansas Department of Otolaryngology-Head & Neck Surgery is seeking a laryngologist, a head and neck surgeon, and a rhinologist/skull base surgeon who are interested in full-time academic positions.

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Laryngologist

Position Number M0204650

Join a busy voice and swallow team with a state-of-the-art laryngeal lab and experienced speech pathology support.

Head and Neck Surgeon

Position Number M0203642

Join a division of four head and neck surgeons. Fellowship in microvascular surgery, surgical oncology and an interest in oncologic research preferred.

Veterans Affair Clinician/Scientist

The Department is looking for a full-time VA position with potential for VA research funding. Ideally this position will allow 50% protected time for research.

PENN<u>STATE HERSHEY</u>

^{Surgery} www.pennstatehershey.org

OTOLOGIST/NEUROTOLOGIST

The Division of Otolaryngology – Head & Neck Surgery at Penn State Milton S. Hershey Medical Center is seeking a full-time board certified Otologist/Neurotologist. Appointment will be at the Assistant/Associate Professor Level. Qualified candidates must have completed an approved residency program. Experience in all aspects of neurotology, otology, cochlear implantation and skull base procedures is desired. Must possess a strong commitment to patient care, resident education, and research.

The Penn State Milton S. Hershey Medical Center is a tertiary care facility that serves central Pennsylvania and northern Maryland. We are a part of a non-profit health organization that provides high-level patient services. Our division is part of a state-ofthe-art, 500-bed medical center, a Children's Hospital, Cancer Center, research facilities, and outpatient office facilities.

Join a growing team of clinical providers with the resources of one of the leading academic medical centers in the nation. Competitive salary and benefits.

Please send inquiries and curriculum vitae to: Fred G. Fedok, M.D., Professor and Chief Division of Otolaryngology – Head & Neck Surgery Penn State Milton S. Hershey Medical Center P.O. Box 850, M.C. H091 Hershey, PA 17033-0850 E-mail: eshultz@hmc.psu.edu

EOE-AA-M/F/H/V

Head and Neck Fellowship

Clinical Focus: Head and Neck Surgical Oncology, Skull Base Surgery, Endoscopic Laser Surgery, Minimally Invasive Endocrine Surgery, Microvascular Reconstructive Surgery and Robotic Surgery.

Applications are accepted through the American Head and Neck Society: **www.ahns.info**.



To view position online, go to http://jobs.kumc.edu (Search by position number.)

Letters of inquiry and CV may be mailed to: Douglas Girod, MD, FACS, Professor and Chairman The University of Kansas School of Medicine Department of Otolaryngology-Head & Neck Surgery 3901 Rainbow Blvd. MS 3010, Kansas City, KS 66160

The University of Kansas School of Medicine is an Equal Opportunity/Affirmative Action employer.

Brigham and Women's Hospital Otolaryngologist

The Division of Otolaryngology, Department of Surgery, at Brigham and Women's Hospital is seeking a BC/BE general otolaryngologist to join our established group. Brigham and Women's Hospital is one of the major teaching hospitals of Harvard Medical School as well as a member institution of the Department of Otology and Laryngology at Harvard Medical School. We are interested in a collegial physician who practices excellent, compassionate clinical care. This position emphasizes community-based otolaryngology.

Interested candidates should send CV and letter of interest to:

Jo Shapiro, MD Chief, Division of Otolaryngology Brigham and Women's Hospital 45 Francis Street, Boston, MA 02115 aschwarzer@partners.org

Brigham and Women's Hospital is an Equal Opportunity/ Affirmative Action Employer. Women and minorities are encouraged to apply.

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- West Palm Beach
- If you're a board-certified ENT/facial plastic or plastic surgeon and would like to learn more, call 866.601.5438.

Otolaryngologist Opportunity

Geisinger Wyoming Valley (GWV) Medical Center, Wilkes-Barre, Pa., is seeking a BC/BE Otolaryngologist.

Geisinger's otolaryngology specialists treat a wide range of conditions of the head and neck by providing the latest technologies in diagnostic, medical, surgical and rehabilitative techniques. We have board-certified and fellowship-trained specialists who collaborate to ensure the most comprehensive care.

About the Position

- Take part in the growth of this dynamic department
- Teach residents
- Pursue research in your area of interest

Medical school loan repayment and residency and fellowship stipends are available.

Geisinger Wyoming Valley (GWV) Medical Center, Wilkes-Barre, Pa., is an acute care hospital that is licensed for 243 beds and houses the only Level II Trauma center in Luzerne County. The campus includes the Frank M. and Dorothea Henry Cancer Center, The Richard and Marion Pearsall Heart Hospital, the Janet Weis Children's Hospital Pediatric Unit, a transplant program and the Brain & Spine Tumor Institute. GWV is affiliated with an accredited Otolaryngology residency program.

Discover for yourself why Geisinger has been nationally recognized as a visionary model of integrated healthcare.

For more information, please visit Join-Geisinger.org or contact: Autum Ellis, Department of Professional Staffing, at 1-800-845-7112 or amellis1@geisinger.edu.

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"Love life. Step into financial success and clinical satisfaction while surrounding yourself with all the beauty and activities the Jersey Shore has to offer."

Fellowship trained Neurotologist, Head and Neck Surgeon and Rhinologist

Coastal Ear, Nose and Throat (Coastal) is an extremely successful three physician private practice located along the shore in Central New Jersey. Coastal's award winning team consists of a two General Otolaryngologists and a fellowship- trained Pediatric Otolaryngologist. We are currently searching for a fellowship trained Neurotologist, Head and Neck Surgeon and Rhinologist to assist in meeting the patient demand for our established, growing practice.

Coastal is associated with the 610-bed Jersey Shore University Medical Center (JSUMC). JSUMC is the academic center of Meridian Health and is the university affiliate of UMDNJ Robert Wood Johnson School of Medicine. Coastal ENT's 11,000 sq ft office and ambulatory surgery center offer state –of- the- art facilities close to the medical center. Ancillary services include: Allergy and Research, full time Clinical Research Coordinator on staff, Vestibular Physical Therapist on site and fully Integrated EMR. Compensation and benefits are highly competitive. Financials are transparent from recruitment to partnership.

Monmouth and Ocean Counties are desirable New Jersey shore communities in close proximity to New York City and Philadelphia. Please feel free to visit our website at www.coastalearnoseandthroat.com.



For immediate consideration, please submit your CV to: Carol A. Petite In House Physician Recruiter Meridian Health cpetite@meridianhealth.com 732-673-5000

SEEKING BOARD CERTIFIED / ELIGIBLE ASSOCIATE

Small, well-regarded private practice group seeking generalist or sub-specialist associate in Head & Neck, Facial Plastic, or Pediatric ENT that is willing to diversify a bit. Good potential for partnership. Diverse practice includes allergy, audiology, vestibular rehabilitation, facial plastic surgery, neurotology, sinus, speech therapy, laryngology and head & neck cancer surgery. Suburban & tertiary care offices in very desireable Pittsburgh, PA area. Good schools, sports, and cultural amenities available. Although primary emphasis is private practice, some teaching opportunity exists. We offer competitive salary, benefits, and a reasonable on-call schedule.

Please contact Diane Lyda @ 412-749-1611 or send CV to: Straka & McQuone, Inc. 1099 Ohio River Blvd., Sewickley, PA 15143

MedStar Georgetown University Hospital

The Department of Otolaryngology-Head and Neck Surgery at Georgetown University Hospital is seeking a BC/BE physician with fellowship training in Otology/Neurotology to join our program. This position presents a unique opportunity for a full time academic surgeon to focus on the care of hearing and balance disorders as well as clinical/basic science research at two of the premier institutions in the metropolitan DC area: Georgetown University Hospital and Washington DC Veterans Affairs Medical Center. The candidate will be active in resident and medical student education and in clinical research.

Georgetown University Hospital is the largest academic medical center in the DC area and is part of the area's largest health care system, MedStar Health. The Washington DC Veterans Affairs Medical Center is a tertiary care teaching facility offering numerous opportunities for basic, translational and clinical research. For 30 years, the VAMC has been one of the major affiliated hospitals for the Georgetown Otolaryngology Residency Program.

Interested applicants should forward an updated CV to:

Bruce Davidson, M.D. Professor and Chairman Department of Otolaryngology-Head & Neck Surgery Georgetown University Hospital 3800 Reservoir Road, NW 1st Floor Gorman Building Washington, DC 20007 202-444-1351 Email: DAVIDSOB@gunet.georgetown.edu



Pediatric Otolaryngology -**Academic Position**

The Department of Otorhinolaryngology is recruiting a third Pediatric Otolaryngologist to join a busy, tertiary Pediatric Otolaryngology practice. This is a unique opportunity to join a rapidly growing Department at a major University Children's Hospital with a large Level III NICU and a Level I Trauma Center. Excellent compensation and benefits. Academic appointment commensurate with experience. Strong interest in resident and medical student teaching and research is encouraged.



Applicants should forward a CV and statement of interest to: Soham Roy, MD, FACS, FAAP Director of Pediatric Otolaryngology The University of Texas Medical School at Houston Department of Otorhinolaryngology-Head & Neck Surgery Soham.Roy@uth.tmc.edu http://www.ut-ent.org

WestVirginiaUniversity.

The Department of Otolaryngology at West Virginia University is seeking a fellowship-trained head and neck surgeon to join a well established head and neck oncology service in the summer of 2013. Expertise with both ablative and reconstructive procedures is desired. Responsibilities include education of residents and medical students and patient care. Opportunities are available for those interested in clinical/basic research

The department currently has ten physician faculty members and fifteen residents and has an active NIH-funded research division with three PhD members.

West Virginia University is located in beautiful Morgantown, which is rated one of the best small towns in America in regard to quality of life. Located 80 miles south of Pittsburgh and three hours from Washington, DC, Morgantown has an excellent public school system and offers culturally diverse, large-city amenities in a safe, family setting.

The position will remain opened until filled. Please send a CV with three professional references to:

Laura Blake Director, Physician Recruitment Fax: 304-293-0230 blakel@wvuhealthcare.com http://www.hsc.wvu.edu/som/otolaryngology/

West Virginia University is an AA/EO Employer. WVU Health Sciences is a tobacco free campus. West Virginia University is the recipient of an NSF ADVANCE award for gender equity.

MEDICAL OTOLARYNGOLOGIST OPPORTUNITY

Geisinger Wyoming Valley (GWV) Medical Center, located in Wilkes-Barre, Pa., is seeking a BC/BE Medical Otolaryngologist.

UTMSH is an equal opportunity employer

About the Position

- Join a team led by a specialist in head and neck surgery, thyroid/parathyroid surgery and sinus surgery
- Work with an experienced general otolaryngologist and a nurse practitioner
- Opportunity to develop new programs such as a dedicated allergy program
- State-of-the-art office with new Kay-Pentax videostroboscopy equipment
- One full-time and one part-time audiologist

Geisinger Health System serves nearly 3 million people in Northeastern and Central Pennsylvania and has been nationally recognized for innovative practices and quality care. A mature electronic health record connects a comprehensive network of 4 hospitals, 38 community practice sites and more than 900 Geisinger primary and specialty care physicians.

Geisinger fosters an atmosphere of clinical excellence while offering an excellent guality of life with good schools, safe neighborhoods with affordable housing and a wealth of cultural and recreational activities. The surrounding natural beauty provides opportunities for fishing, skiing, canoeing, hiking and mountain biking. Urban life is easily accessible, with New York, Baltimore, Philadelphia and Washington D.C. just an afternoon's drive away.

Discover for yourself why Geisinger has been nationally recognized as a visionary model of integrated healthcare.

For more information, please visit Join-Geisinger.org or send your CV and cover letter to:

Autum Ellis, Department of Professional Staffing, at 1-800-845-7112 or amellis1@geisinger.edu



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Special Opportunity Rhinebeck, New York

Northern Dutchess ENT

The Center of Excellence for Sinus, Ear and Throat Care

We are seeking a general BC/BE otolaryngologist to join our two physician practice. We are located in the beautiful mid- hudson river valley with offices in Rhinebeck and Kingston. The area offers great cultural and recreational opportunities with an excellent school system, New York city is one and a half hour by train.

We provide general ENT services with an in-office ct scanner and special emphasis on rhinology. We have a strong audiology and balance department including hearing aid dispensing. The practice is very successful and financially sound, it is well regarded by both the patients as well as the medical community.

The compensation and benefit package is excellent. The model for partnership is unique and flexible.

We have succeeded over the years in maintaining a healthy and a much needed balance between our personal and professional lives.

> Contact: Nader Kayal, MD, COPM Managing partner Northern Dutchess ENT, PLLC 845-518-7780 entdoc53@aol.com

Children's Mercy HOSPITALS & CLINICS Kansas City

Children's Mercy Hospitals and Clinics – Kansas City is seeking fellowship trained Pediatric Otolaryngologists to join our professional staff at the assistant or associate professor level. The position would entail clinical care, research, and teaching of medical students, and pediatric and otolaryngology residents.

Our active Pediatric Otolaryngology Division provides comprehensive tertiary patient care in a family-centered environment. There are currently 7 pediatric otolaryngologists on staff, as well as 3 neurotologists. In addition, our ACGME-accredited pediatric otolaryngology fellowship welcomed our 4th fellow this July, 2012.

Children's Mercy Hospitals & Clinics is a large pediatric health care system that is affiliated with the University of Missouri-Kansas City School of Medicine. The main hospital is growing to nearly 400 beds this year with plans to expand to 41 PICU beds and 80 NICU beds.

Kansas City is a bi-state community with close to 2 million residents who enjoy an excellent quality of life. There is a robust offering of arts and entertainment, with a number of new venues having just opened within the past few years. The Kansas City metroplex contains a wide selection of highly rated public and private schools. We are also the regional home to several major colleges and universities. Salary and academic range are commensurate with experience. EOE/AAP

> Robert A. Weatherly, MD Division Director; Ear, Nose, and Throat rweatherly@cmh.edu Phone: 866-CMH-IN-KC/866-264-4652 www.childrensmercy.org

South Florida Associates, P.A. South Florida ENT Associates, a forty five Otolaryngology group practice in Miami Dade and Broward has immediate openings for full- time ENT Physician's. One location is a busy 2 physician, 2 office practice that is located in Broward County, in the Weston/Pembroke Pines area. Another location is a busy 4 physician, 4 office practice located in Dade County, in Aventura, Coral Gables and Miami. They are both full service ENT practice's with Audiology, Hearing Aid sales and Allergy. We offer an excellent salary/bonus with partnership track, health insurance, paid vacation time, malpractice insurance and CME reimbursement, plus other benefits. Candidate must have strong clinical knowledge, excellent communication skills, be highly motivated and hardworking. This position will include both office and hospital setting. **Requirements:** Must be board certified within 24 months of commencing employment MD/DO from approved medical/osteopathy school and graduation from accredited residency program in ENT Current Florida license Bilingual (English/Spanish) preferred Excellent communication and interpersonal skills. ENT Experience a must F/T - M-F plus call

Contact Information Contact name: Stacey Citrin, CEO Phone: (305)558-3724 E-mail: scitrin@southfloridaent.com Cellular: (954)803-9511

Broward Location: Jonathan Cooper, MD (954)389-1414 jcooper@southfloridaent.com Cellular: (954)816-1087 Dade Location: Horacio Groisman, MD Phone: (305)325-0900 horaciogroismanmd@gmail.com

West Virginia University.

The Department of Otolaryngology/Head & Neck Surgery at West Virginia University is seeking a general otolaryngologist to join a thriving academic practice in the summer of 2013. Applicants must be board certified/eligible by the American Board of Otolaryngology. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

The department currently has ten physician faculty members and fifteen residents and has an active NIHfunded research division with three PhD members.

With a metro area population of over 115,000, Morgantown, WV, is consistently rated as one of the best small cities in the U.S., with affordable housing, excellent schools, a picturesque countryside, many outdoor recreational activities, and close proximity to major cities, such as Pittsburgh, PA, and Washington, DC.

The position will remain opened until filled. For more information please contact:

Laura Blake Director, Physician Recruitment blakel@wvuhealthcare.com Fax: 304.293.0230 http://www.hsc.wvu.edu/som/otolaryngology/

West Virginia University is an AA/EO Employer. WVU Health Sciences is a tobacco free campus. West Virginia University is the recipient of an NSF ADVANCE award for gender equity.



UNIVERSITY OF CALIFORNIA, LOS ANGELES General Otolaryngologist (full-time clinical, non-tenure track)

The Department of Head & Neck Surgery at the David Geffen School of Medicine at UCLA is seeking a general otolaryngologist to join its clinical faculty in the Santa Monica office. The position has both clinical and surgical responsibilities. Candidate should possess excellent communication skills and be a team player. Applicant must be Board certified (or eligible) and have a current California medical license.

Send letter of inquiry & curriculum vitae to: Gerald S. Berke, M.D., Professor and Chair UCLA Department of Head and Neck Surgery 10833 Le Conte Avenue, CHS 62-132 Los Angeles, CA 90095-1624 Unique Opportunity in Sunny South Florida For Motivated ENT

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Please contact: Perry Giordanelli, 954-748-1508

University Hospitals

Head and Neck Surgery and Reconstruction Fellowship

The Department of Otolaryngology-Head and Neck Surgery in conjunction with University Hospitals Case Medical Center and the Seidman Cancer Center is proud to announce the establishment of a one-year Head & Neck Surgery and Reconstruction fellowship beginning July 2014. The head and neck surgical team includes Drs. Pierre Lavertu, Rod Rezaee and Chad Zender.

This one year fellowship offers advanced training in:

- Microvascular free tissue transfer
- Over 120 cases per year
- Endoscopic and open skull base surgery
- Minimally invasive head and neck surgery
- Transoral laser and transoral robotic surgery
- Sentinel node mapping for head and neck melanoma

Clinical duties

Fellowship requirements and opportunities include:

- Teaching residents and medical students
- 1-11 call
- Clinical or basic science research
- Participation in our resident microvascular course and skull base workshop
- Travel and presentation at national meetings
- Productivity bonus in line with a competitive fellowship salary

Applicant requirements:

- Completion of an ACGME accredited Otolaryngology-Head and Neck surgery residency
- ABO board eligible or certified
- Ohio Medical license eligible

Please visit http://uhhospitals.org/ENT to view the position online and to submit CV for consideration.

For more information please contact: Chad Zender, MD, FACS

Assistant Professor and Fellowship Director

University Hospital-Case Medical Center Department of Otolaryngology-Head and Neck Surgery

Chad.Zender@UHhospitals.org

216-844-5307



The Department of Otolaryngology – Head & Neck Surgery and Myles L. Pensak, MD, FACS, H.B. Broidy Professor and Chairman, are expanding its clinical/ academic programs and have the following full-time openings:

- Board certified General Otolaryngologist
- · Board certified fellowship-trained Laryngologist

Both positions require a strong interest and commitment to the education of residents, fellows and medical students. Academic appointment will be commensurate with experience/qualifications. MD/DO degree and the obtainment of a permanent Ohio medical licensure required.

Interested candidates should send a letter of interest, CV and a list of three references to: barbarag.huber@uc.edu

--The University of Cincinnati is an equal opportunity and affirmative action employer--



South Florida Associates, P.A.

A. Clifford Foster, M.D., F.A.C.S. Jorge Helo, M.D. Paul K. Foster, M.D.

Seeking an ambitious Otolaryngologist for a small general ENT practice to replace a retiring member.

- Associated but independent from Mount Sinai Medical Center in Miami Beach, FL., as well as several ambulatory surgical centers.
- Design your own practice, General ENT + whatever focus you like.
- In-Office Balloon Sinuplasty, in office allergy immunotherapy
- Operate with state of the art equipment
- Hospital with da Vinci Robot available.
- Competitive Salary Base plus percentage.
- 4 weeks vacation.

• Malpractice, 401 (k), health insurance.



Must be BC/BE.

Please Contact: Dr. Paul K. Foster 4302 Alton Rd., Suite 650 Miami Beach, FL 33140 drpkfoster@gmail.com



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