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American Academy of Otolaryngology—Head and Neck Surgery February 2013—Vol.32 No.02

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American Academy of Otolaryngology—Head and Neck Surgery February 2013—Vol.31 No.10

The New Marker of a Physician's Skill: Educating Community Via Our Outreach Campaigns

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AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

David R. Nielsen, MD
Executive Vice President, CEO, and Editor, the *Bulletin*

Letters to the Editor Questions, concerns, or comments about *Bulletin* articles and other content may be addressed to the Editor via email at bulletin@entnet.org.

Article Submissions Author guidelines are online at www.entnet.org/press/bulletin/ and AAO-HNS members are encouraged to submit articles via email to bulletin@entnet.org. *Bulletin* staff will contact the author at the completion of the editorial review process for any article submitted.

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bulletin

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

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EMPOWERING PHYSICIANS TO DELIVER THE BEST PATIENT CARE

Kids ENT Health and the Academy: Then and Now

"Many things can wait; the child cannot. Now is the time his bones are being formed, his mind is being developed. To him we cannot say tomorrow; his name is today."
— Gabriela Mistral (1889-1957), the first Latin American woman to win a Nobel Prize in Literature

For a decade now, this Academy has been using the month of February to promote children's ear, nose, throat, head, and neck health. The official name of the observation is Kids E.N.T. Health Month.

In 2003 we asked "Why Kids E. N. T. Health?" Children suffer from maladies and issues of the ears, nose, and throat and related structures more often than any other part of the body. Providing parents, caregivers, referring physicians, and allied health professionals the most up-to-date information on the diagnosis and treatment of childhood ear, nose, and throat disorders is crucial to the health and wellness of America's children.

Research has shown that sensory development [in a safe environment] is a necessity for children to fully explore their environment and enjoy an uninhibited learning experience. Left untreated or improperly treated, illnesses involving the ears, nose, and throat, can impede proper development of the senses, leading to learning disabilities.

Since then, the campaign's focus and the Academy's work not only has included clinical issues affecting children, but also has dealt with social issues such as supporting legislation for newborn hearing screening, pointing out the dangers of second-hand smoke, environmental noise pollution, and the perils of ingesting foreign objects.

Past campaigns reached many communities. Between 2003 and 2007, the campaign attracted grassroots media, and garnered millions of impressions nationwide including two syndicated publications: Health Behavior News Service [a tool for health reports]: "Non-steroidal anti-inflammatory drugs and preoperative bleeding in tonsillectomy;" and "Administration of antibiotics to children aged five and younger if green nasal discharge is present," in *Parenting Magazine* with more than two million readers. Also of note was the NAPS Extraordinary Achievement Award in 2005 for 753 radio airings for "Treating Allergies Seriously" from this syndication service, placing it in the top one-quarter of one percent of all its releases, including most Fortune 500 companies and more than 100 associations, the Top 12 public relations firms, and 1,600 accounts.

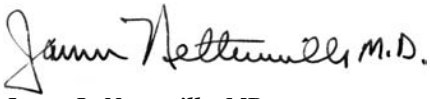
2013 Outreach Now

Much has changed since 2007, including the spread of information technology, which has allowed healthcare providers to collect more information more quickly and be able to analyze treatment options and see their outcomes.

The AAO-HNS/F has been making the most of this through Research and Quality Improvement (R and QI) activities. The R and QI activities include the garnering of systematic evidence-based data to develop guidelines and consensus statements for Members to use in improving care. Both clinical and educational committees of the Academy and Foundation participate in guideline development, as do consumer groups.

The theme for this year's outreach campaign is "Kids E.N.T. Health: Safety." **David E. Tunkel, MD,** Pediatric Otolaryngology Committee chair, with **Ian N. Jacobs, MD,** of that committee, contributes information on two children's health safety issues. **Wendy B. Stern, MD,** chair of the Media and Public Relations Committee, gives us a wonderful overview of what it means to champion children's health issues in our communities today. In addition, our Foundation in partnership with the American Society of Pediatric Otolaryngology, is offering a 10-webinar series on vital care topics outlined on page 24.

Of course, there are still many issues surrounding children's E.N.T. Health to address. In 2012, 15 states still did not require newborn hearing screening. With information traveling so quickly, we have a wonderful opportunity to make use of emerging networks of health bloggers and mobile bloggers to extend the reach of our own grassroots educational efforts.



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

Academy Helps Members to Extend Care

Unique Academy campaign resources, available to members through the Academy's website, can be used to begin the campaign in your community. Here you will find a list of resources at www.entnet.org/AboutUs/KidsENT.cfm.

The communications staff is also available for consultation and support. Our government affairs and regulatory advocacy teams are constantly promoting health and access-to-care issues with legislators and regulatory agencies.

As we think of educating our communities this month, also be aware of the opportunities to work with patients in discussing treatments that are right for them. As you know, the AAO-HNSF has joined 32 other medical specialty societies and the American Board of Internal Medicine (ABIM) Foundation (34 total) in the *Choosing Wisely*® campaign to promote wise choices between physicians and patients to improve healthcare outcomes, provide patient-centered care that avoids unnecessary and even harmful interventions, and reduce the rapidly-expanding costs of the healthcare system.

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The Power of Personal Influence

David R. Nielsen MD

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

I fondly remember as a child that the month of February was a celebratory month, a patriotic month—almost like July, in which we focus on our political freedoms and our independence as a nation. Of course, this was primarily because of the two separate holidays recognizing the birthdays of Presidents George Washington and Abraham Lincoln. The influence for good that the lives of these two men still engender is remarkable. Even though we combine our recognition of their contributions to our national, political, and moral foundations into one single holiday, Presidents Day, their popularity as leaders and their power to influence our thinking and our popular culture is arguably as great today as it has ever been. We have added to this season of recognition the name of Dr. Martin Luther King, Jr., whose life, courage, and vision for social justice and political equality we honor each year during the month of January. Globally, we can think of many others—Churchill, Gandhi, and Mother Theresa—who define the actions of great people who have inspired our collective conscience to greater humanity.

> There is no greater calling than to positively change lives by restoring to strength and vigor when possible those who are weak and sick among us.

Reflecting on these leaders has caused me to want to reprise a sentiment I expressed before. More than 100 years ago, the editor of *The Saturday Evening Post*, William George Jordan, a great humanist, lecturer, and essayist, described in his monograph, "The Majesty of Calmness," what he termed, "the power of personal influence." He correctly points out that we all influence the world around us, whether we know it or not…or even intend to do so. He writes, "The only responsibility that a man cannot evade in this life is the one he thinks of least, his personal influence. Man's conscious influence, when he is on dress-parade, when he is posing to impress those around him, is woefully small. But his unconscious influence, the silent, subtle radiation of his personality, the effect of his words and acts, the trifles he never considers, is tremendous. Every moment of life he is changing to a degree the life of the whole world."[1]

During the last year, I have been impressed with the number of amazing people I know, many of them colleagues, members and leaders of the Academy and subspecialties, who quietly go about doing great work and great good. They seek no personal recognition, nor are they motivated by money or power. Those who are among our ranks as physicians have a deep-seated desire to improve the world around them, contribute to the relief of their patients, and help find solutions to the many perplexing issues facing American medicine today. Although I would like to mention them by name, I cannot begin, because even a cursory list would take up more space than this entire column. But I take the time and space in this article to honor you, my colleagues, for your quiet heroism, for the daily battles you fight and win to give more than you get, how you serve with cheerfulness those who are suffering, and heal, inspire, and encourage those beset with poor health or disability. There is no greater calling than to positively change lives by restoring to strength and vigor when possible those who are weak and sick among us.

I have saved some last minute comments to remind us of what will be old news by the time this is published: that the Congress has again delayed acting on the fiscal imperatives facing the nation, including a permanent solution to the untenable SGR formula. What does this have to do with our honored heroes? While we may have a tendency to romanticize the lives of those listed above, they forged their reputations in great political, social, financial, and personal struggle. As dire as our current economic situation may seem, it probably pales compared to the political, economic, and social uncertainties our Founding Fathers faced. We cannot take over Congress' job, but we can choose to act, rather than be acted upon. Let us embrace quality improvement for its own sake and the benefit of our patients, not for political reasons. Let us engage in the *Choosing Wisely*® campaign by personally examining and identifying ways in which we can avoid unnecessary or needlessly expensive care; educating our patients about the best use of resources; and being stewards of the public health and the health of our individual patients. You will hear more in the next few months about the Academy's public stance to improve health and partner with other physician organizations to provide the best care possible, which is our vision.

Reference

1. 1. Jordan, William George. The Majesty of Calmness; Individual Problems and Possibilities. Electronic version produced by Curtis A. Weyant, Charles Franks, and the Distributed Proofreading Team; Chapter Three: The Power of Personal Influence (original publication 1900).

Get Involved in Your Academy—2013 BOG Spring Meeting & OTO Advocacy Summit

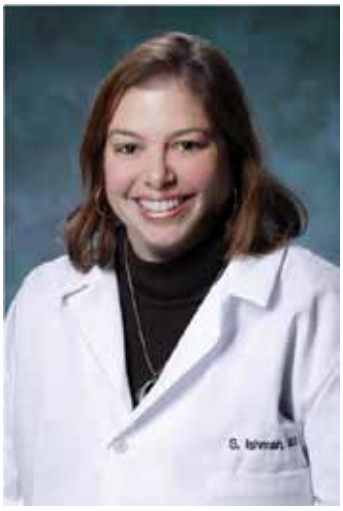
Stacey L. Ishman, MD, MPH
BOG, Member-at-Large

The future of healthcare and our role in it has never seemed more uncertain. Acronyms abound with ACA, ACOs, SGR, IPAB, PQRI, and the list continues. Luckily, we have the Academy's resources to interpret the alphabet soup and help us discern where we need to focus our limited time and resources. Just as important, our Academy is constantly working for us whether we have the time to notice or not. It lobbies on Capitol Hill in Washington, DC, pays attention to bills that affect us in every state legislature, and works to represent our interests to insurance companies, guideline development organizations, and the media.

There are myriad options for involvement, including support of the Academy through our dues, committee work, and the Millennium Society. In addition, everyone is invited to participate in the Board of Governors (BOG) meetings, which occur twice a year and address the legislative and socioeconomic issues affecting our practices and our patients.

ENT PAC, the AAO-HNS political action committee, has also been critical in representing our interests with its bipartisan support of federal candidates. Impressively, 90 percent of the legislators supported by ENT PAC have been re-elected, reflecting the work the ENT PAC board and staff have done to ensure that we support candidates who can effectively advance the interests of otolaryngology.

For those who want to be directly involved in these discussions, the Academy is happy to direct and support you in the process. The Academy will again sponsor the **BOG Spring Meeting & OTO Advocacy Summit**, which will take place **Sunday, May 5, through Tuesday, May 7,** in Alexandria, VA, and Washington, DC. This joint conference provides opportunities to network with our grassroots colleagues and explore timely issues in interactive sessions specifically geared to our members' interests, whether they are a resident/fellow, young physician, in private practice, in academia, or serving in the military. Attendees will also receive advocacy training, education about the legislative process and the current legislation affecting us at the federal level, and be able to lobby our legislators. I have participated since my residency and have found the experience incredibly gratifying. The training sessions have served me well on the Hill and in my department chair's office. I also have been able to better understand the alphabet soup and its effect on my practice and medicine in general. For anyone who has not participated, I cannot emphasize enough what a fantastic opportunity this is to learn about the legislative process while having access to the giants in our field. In addition, this meeting is coordinated with the meetings of the Board of Directors and Board of Governors to facilitate participation and access.



If you are not able to attend the OTO Advocacy Summit, consider becoming involved in the **ENT Advocacy Network**, which includes nearly 1,700 members. While only 15 percent of all U.S. Academy members are members of the Network, more than 3,700 emails were sent to legislators this year through the network. Please consider joining us in the effort.

February is also when we have traditionally celebrated and publicized our care of children with otolaryngic issues. Kids E.N.T. Health is designed to offer parents and caregivers the latest information about the care, diagnosis, and treatment of pediatric ear, nose, and throat disorders. Past campaigns have focused on ear tube placement and sleep-disordered breathing. Journalist resources include legislative information, Academy information, patient health information, scientific meeting information, policy statements, and patient fact sheets. This information can be used to publicize your practice and advance the public understanding of pediatric otolaryngology care.

Please consider participating in the process, whether through participation in the BOG Spring Meeting & OTO Advocacy Summit, the ENT Advocacy Network, or by providing public outreach and publicity through your local media outlets. I hope to see you at the 2013 Board of Governors Spring Meeting & OTO Advocacy Summit.

Note: To get involved or find out more, go to www.entnet.org/getinvolved

> "Luckily, we have the Academy's resources to interpret the alphabet soup and help us discern where we need to focus our limited time and resources."

Otolaryngology in Our Nation's Capital: A History

Kenneth M. Grundfast, MD,
Jacob B. Kahane
The Otolaryngology History Society

The history of otolaryngology in our nation's capital is unique. Otolaryngology in Washington, DC, has encompassed care provided to United States presidents, members of Congress, military personnel, government workers, and ordinary citizens.

In 1799, General George Washington was treated for acute epiglottitis in his Mount Vernon home. President Grover Cleveland underwent a partial maxillectomy, secretly performed as treatment for a verrucous carcinoma of the palate.

Prior to World War II, Washington was a relatively small city, but after World War II, it became the downtown hub of a metropolis comprising Maryland and Virginia suburbs. Today, metropolitan Washington, DC, has three civilian medical schools with associated teaching hospitals, the Walter Reed National Military Medical Center including a military medical school, and the National Institutes of Health.

> The Episcopal Eye, Ear, and Throat Hospital, founded in 1897, evaluated soldiers for combat readiness in World War I. This hospital eventually merged with others to form the Washington Hospital Center, now a teaching hospital for Georgetown University.

The Episcopal Eye, Ear, and Throat Hospital, founded in 1897, evaluated soldiers for combat readiness in World War I. This hospital eventually merged with others to form the Washington Hospital Center, now a teaching hospital for Georgetown University. The earliest known chairman of otolaryngology at Georgetown University School of Medicine was Walter A. Wells, MD, who wrote a medical thesaurus.

In 1914, Ulysses Houston, MD, founded the department of otolaryngology at Howard University Medical School and Freedmen's Hospital, now named Howard University Hospital. Clarence Hinton, MD, chair of otolaryngology at Howard from 1963–1979, was the first African American to become chair of the DC Medical Society's otolaryngology division.

The Children's Hospital, founded in 1870, has become the Children's National Medical Center with a large and well-respected otolaryngology department. Interestingly, Washington, DC, is home to both the Gallaudet University, the nation's only university for the deaf, and the Food and Drug Administration, which gave approval for the cochlear implant that has diminished the size of the deaf population.

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Robert Ruben, MD (left) and guest, Dara (Grundfast) Eisner, and Kennth M. Grundfast, MD (right).

Revisiting Max Brödel's 1939 Classic Coronal Illustration of the Ear

Robert K. Jackler, MD, Christine Gralapp, Albert Mudry, MD, PhD for the Otolaryngology Historical Society

In 1939, the renowned Johns Hopkins medical artist Max Brödel created a coronal illustration of the ear (figure 1). Brödel's magnificent and hugely successful illustration drew upon artistic conventions developed during the preceding 200 years. It nevertheless constituted an important improvement over prior depictions in large part due to his consummate skill as an illustrator. As a schematic, it provided clarity to complex anatomical relationships in a manner that was readily understandable.

For nearly seven decades, Brödel's magnificent illustration has served as the inspiration for innumerable textbook and article illustrations. In his design, the artist intentionally choose to diverge from literal anatomy in that he distorted some structures (such as rotating the incus 180 degrees, bending the cochlea anteriorly, and substantially enlarging the inner ear) to bring them into greater prominence and clarity and eliminated others (such as the carotid artery and intratemporal facial nerve) to avoid a cluttered image. Several anatomical errors exist, such as the absence of the scutum and a markedly foreshortened internal auditory canal.

Brödel's illustration has been routinely imitated by subsequent illustrators (in collaboration with otologists) and virtually all have faithfully reproduced Brödel's purposeful artistic distortions and unintentional errors in their depictions—often with the assumption that they represented actual anatomy rather than an artistic interpretation. Perpetuation of distortions and errors in anatomical illustration is not a rare phenomenon. This led us to offer a more anatomically accurate standard coronal schematic of the ear, created by artist Christine Gralapp in collaboration with Drs. Robert Jackler and Albert Mudry, which we hope will enhance the clarity and precision of future illustrations in the otological literature (figure 2).

These articles are based on papers presented at the Otolaryngology Historical Society meeting, September 10, 2012. If you are interested in presenting at the next OHS meeting, Vancouver, BC, Canada, September 30, 2013, 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) at clincoln@entnet.org or call 1-703-535-3738.

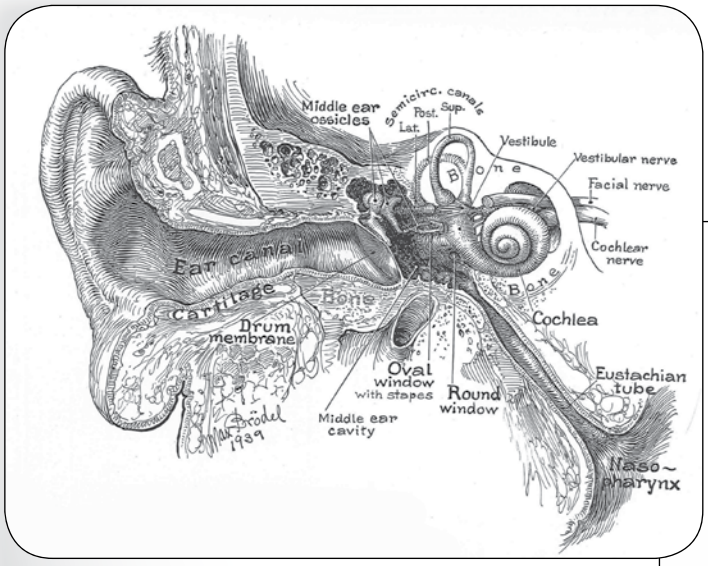

Figure 1. Max Brödel's 1939 Classic Coronal Illustration of the Ear (now in the public domain).

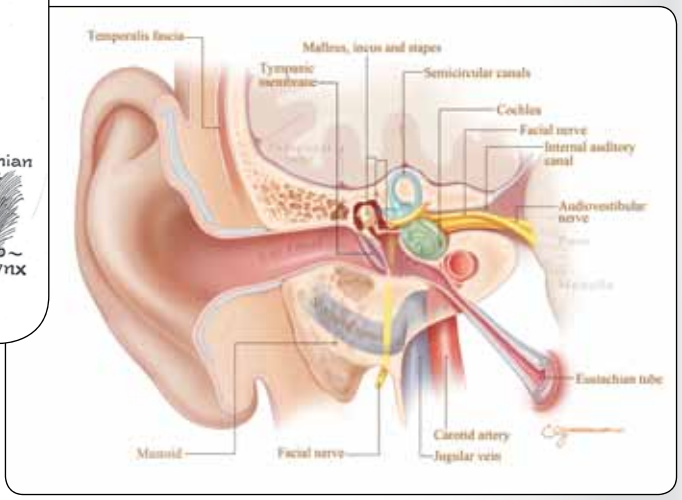

Figure 2. The comparison illustration is "reproduced by courtsey of Stanford University."

Health Policy 101: What Health Policy Does for Members

The Academy's Physician Payment Policy (3P) Workgroup is the senior advisory body to Academy leadership and staff on issues related to socioeconomic advocacy, regulatory activity, coding and reimbursement, and practice services or management. 3P and the Health Policy staff work to ensure that members' interests are appropriately represented. 3P oversees the review and content for the Clinical Indicators and the Policy Statements, provides resources to Members, such as template appeal letters, and CPT for ENT coding guidance articles. Coordination with other Academy committees, subspecialties, and medical specialty societies are critical to 3P's success.

Health Policy has two coordinators, who are also the Physician Payment Policy (3P) Workgroup Co-Chairs.

James C. Denneny, III, MD, coordinator for Socioeconomic Affairs, oversees all coding and payment issues related to Medicare and the Academy's efforts to influence the CPT coding and RVS systems through work with the Academy's members and advisors on the AMA's CPT Editorial Panel, the Relative Value Update Committee (RUC), and the RUC's Practice Expense Review Committee (PERC). He also works closely with the Government Affairs Business Unit and Health Policy department to achieve these directives.

Dr. Denneny is on the Socioeconomics Committee of the Board of Governors of the ACS and also on its Executive Committee of the Board of Governors. These positions open synergistic opportunities to increase cooperation and build coalitions among the surgical societies as we try to navigate an increasingly hostile landscape for physicians, particularly surgeons. Finally, he is working with other Academy leaders from Research and Quality and the Board of Directors to review potential prospective payment models for possible use by otolaryngology-head and neck surgeons in the future.

Michael Setzen, MD, coordinator for Practice Affairs, is responsible for developing and maintaining programs that support and provide practice management-related answers to health policy issues. The coordinator will spearhead collaborative efforts with other specialty societies on priority payer reimbursement issues related to private health insurance policies, publication of the Socioeconomic Survey, and providing input on any related educational programs for the annual meeting.

In addition, the coordinator is responsible for publishing periodic practice management articles for the Academy's *Bulletin*. Dr. Setzen works closely with Dr. Denneny to ensure a high quality of programs for delivery to both the Board of Directors and to members.

Note: **Jane T. Dillon, MD,** is coordinator-elect for Practice Affairs and will begin her term in October 2013.

More of What Health Policy Does for Members

- Regulatory and Socioeconomic Advocacy
  - Advocate for AAO-HNS members for fair policies by providing comments and meeting face-to-face with the Centers for Medicare and Medicaid Services (CMS) and private payers on ongoing/unresolved otolaryngology-specific issues.
  - Support volunteer participation in RUC and CPT meetings.
  - Partner and participate strategically, with other organizations and stakeholders (e.g. CMS, HHS, AMA, ACS, etc.) in health policy initiatives to ensure our specialty is represented in future payment model development.
- Practice Affairs-Business of Medicine
  - Provide members and payers/public with comments and guidance (including Clinical Indicators and Position Statements) to represent AAO-HNS members on major payer issues of relevance.
  - Provide coding guidance (ie, ICD10 transition, new codes, etc.) and develop coding articles for publication in *The News* and *Bulletin*.
  - Develop Health Policy annual meeting programming on topics that are timely, relevant and practical

More AAO-HNS Website Resources

- Clinical Indicators http://www.entnet.org/Practice/policystatements.cfm
- Policy Statements http://www.entnet.org/Practice/clinicalIndicators.cfm
- Template Appeal Letters for Patient notification of in-office diagnostic procedures listed as surgery (new); septoplasty (new); image guidance; microsurgical techniques using microscope; modifier 22; modifier 25; unlisted procedure: http://www.entnet.org/Practice/Appeal-Template-letters.cfm
- Members only, view previous socioeconomic surveys: http://www.entnet.org/Practice/members/socioeconomic.cfm
- Zupko Coding Workshops: http://www.entnet.org/ConferencesAndEvents/codingworkshops.cfm
- eRx resources: http://www.entnet.org/Practice/MedicareERxFactSheet.cfm
- Meaningful Use EHRs: http://www.entnet.org/Practice/ONC.cfm

See list next page

Health Policy Glossary Resource List

AMA = American Medical Association

CAC = Medicare Contractor Advisory Committee

CPT code = Current Procedural Terminology

CMS = Centers for Medicare & Medicaid Services

EHR/EMR = Electronic Health/Medical Record

ICD-9/ICD-10 = International Classification of Diseases, with "n" = "9" for Revision 9 or "10" for Revision 10, with "CM" = "Clinical Modification," and with "PCS" = "Procedure Coding System."

MAC = Medicare Administrative Contractor

MU = Meaningful Use

RUC = Relative Value Scale Update Committee

RVU = Relative Value Unit

Resource:
http://www.cms.gov/apps/glossary/default.asp?Letter=A&Language=English

Dates to Remember

At AAO-HNS/F

February 1
2013 Committee Application Opens on November 15 and closes on February 1. See www.entnet.org/committees.

February 1-2
Coding and Reimbursement Workshop, Dallas, TX, at www.entnet.org/coding.

February 1
Otolaryngology Historical Society call for papers opens. Email museum@entnet.org.

February 15-16
Coding and Reimbursement Workshop, Hilton Orlando Buena Vista, Orlando, FL
see www.entnet.org/coding.

March 8-9
Coding and Reimbursement Workshop, Encore at Wynn, Las Vegas, NV. See www.entnet.org/coding.

April 8
Housing deadline for BOG Spring Meeting & OTO Advocacy Summit. Visit www.entnet.org/bog&summit.

April 12-13
Coding and Reimbursement Workshop, Drake Hotel, Chicago, IL. See www.entnet.org/coding.

April 15
International Travel Grant application deadline. Email international@entnet.org.

April 16
World Voice Day

April 14-20
Oral Head and Neck Cancer Awareness Week

In Otolaryngology

Details at www.entnet.org/conferencesandevents.

February 2-3
ACS Thyroid and Parathyroid Ultrasound Skills-Oriented Course

February 8-9
81st Midwinter Research Study Club of Los Angeles Recent Advances in Otolaryngology—Earn up to 16 CME Credits

February 14-17
2013 Advanced Techniques in Endoscopic Sinus Surgery

February 15-17
19th Annual Advances in Diagnosis and Treatment of Sleep Apnea and Snoring

February 16-19
UCSF/Tripler Pacific Rim Otolaryngology Head and Neck Surgery Update Conference

February 16-19
The UC Irvine 2013 Otolaryngology Updates, 28.0 AMA PRA Category 1 Credits™

February 16
Head & Neck Radiology Bootcamp, 3.25 AMA PRA Category 1 Credits™

February 17
The Fourth Annual Injectable Fillers and Neuromodulators Course, 3.25 AMA PRA Category 1 Credits™

Choosing Wisely®—Our List of "Five Things Physicians and Patients Should Question" Coming Soon

The American Academy of Otolaryngology—Head and Neck Surgery Foundation, a proud partner in the *Choosing Wisely*® campaign, will join 17 medical specialty societies on **February 21,** in releasing evidence-based lists of tests and procedures that may be overused.

The goal of the campaign is to encourage conversations between physicians and patients about using the most appropriate tests and treatments and avoiding those that may be unnecessary and those in which the harms may outweigh benefits.

Choosing Wisely, an initiative of the American Board of Internal Medicine (ABIM) Foundation, sparked a nationwide conversation when its initial lists from nine societies were announced last spring. The campaign received extensive media coverage by cable and network television, radio, blogs, social media, and the nation's major newspapers.

Choosing Wisely®

An initiative of the ABIM Foundation

Millions of consumers, physicians, and stakeholders are well aware of the issue of unnecessary tests and procedures in healthcare, and are having conversations about them. The media outreach to date has reached nearly 116 million Americans.

The Foundation, the first surgical society to join the campaign, will present its list of "Five Things Physicians and Patients Should Question" this month during the campaign's news conference in Washington, DC. The Patient Safety and Quality Improvement Committee (PSQI) was charged with developing the Foundation's recommendations. The list was carefully developed with input from the Specialty Society Advisory Council (SSAC) and was reviewed by the appropriate committees and the Guidelines Development Task Force (GDTF). The Foundation Board approved it.

In advance of the coming announcement, we wanted to share with you some of the guiding principles and goals of the *Choosing Wisely* campaign:

- Promote conversations between physicians and patients about using the most appropriate tests and treatments and avoiding those that could do more harm than good—recognizing that all healthcare must be appropriate for the individual patient.
- Support and engage physicians in being better stewards of healthcare. As much as 30 percent of healthcare in the United States is duplicative or unnecessary, as reported by the Institute of Medicine.[1]
- Help patients and physicians answer the question of how to have the needed conversations to make sure the right care at the right time is delivered. Physicians need help in responding to patients who ask for tests and procedures that may not be necessary.

Each specialty developed lists using the most recent evidence about management and treatment options in that specialty. As *Choosing Wisely* notes, the lists are recommendations from physicians themselves.

The specialty societies participating in the phase two February announcement include:

- American Academy of Hospice and Palliative Medicine
- American Academy of Neurology
- American Academy of Ophthalmology
- American Academy of Otolaryngology—Head and Neck Surgery
- American Academy of Pediatrics
- American Congress of Obstetricians and Gynecologists
- American College of Rheumatology
- American Geriatrics Society
- American Society for Clinical Pathology
- American Society of Echocardiography
- American Urological Association
- Society of Cardiovascular Computed Tomography
- Society of Hospital Medicine
- Society of Nuclear Medicine and Molecular Imaging
- Society of Thoracic Surgeons
- Society for Vascular Medicine

More societies are developing lists for release in mid-2013 and some current partners, including the Foundation, will develop second lists.

We are enthusiastic about the potential to address in a practical manner ways to reduce waste, improve quality care, and engage physicians and their patients in making better healthcare choices. *Choosing Wisely* complements the Foundation's quality agenda that focuses on empowering physicians to provide the best patient care through the development of evidence-based guidelines; identifying tools, services, and processes that lead to safe care in otolaryngology–head and neck surgery.

For more information about the *ChoosingWisely* campaign, visit www.choosingwisely.org.

Reference:

1. http://www.nap.edu/catalog.php?record_id=13444

The Academy Quality Agenda: Past, Present, and Future

Richard M. Rosenfeld, MD, MPH
Senior Advisor for Guidelines and Quality

During the past decade Academy leadership has quietly established a robust quality agenda, one that has positioned us as a leader in evidence-based medicine and clinical practice guideline development. We have reached a tipping point in our success, offering a unique opportunity to reflect on the past, appreciate the present, and to consider what the future might hold.

Note: The comments that follow emphasize guidelines and measures, which are a key aspect of the quality agenda, but only part of the Academy's diverse initiatives.

Drs. Rosenfeld and Waguespock discuss with attendees the scope and detail of a guideline.

Research and Health Policy

The Tipping Point

Author Malcolm Gladwell defines the tipping point as "the moment of critical mass, the threshold, the boiling point." So what does this have to do with a quality agenda? Quite simply, we have reached the stage where the quality agenda has changed from an intellectual exercise to an eminently pragmatic—and essential—aspect of clinical practice that can empower otolaryngologists.

Consider, for example, our ability to handle five significant external threats to physician autonomy because of our quality agenda:

1. When the Joint Commission (JC) and American Medical Association (AMA) recently questioned the appropriateness of tympanostomy tube insertion in children we were able to rapidly mobilize a multidisciplinary guideline development group (including consumers), engage JC and AMA leadership in the process, and demonstrate our sincere commitment to addressing any quality concerns while preserving our member's ability to perform necessary and appropriate surgery (2013 publication date).
2. When WellPoint, home of the Anthem and Empire Blue Cross/Blue Shield insurance plans, began inappropriately denying tonsillectomy for children with sleep apnea or younger than age three with sleep-disordered breathing, we rapidly mobilized Academy Research and Health Policy leadership and used our quality products—guidelines on tonsillectomy and polysomnography—to achieve a prompt rewrite of the national WellPoint medical necessity policy with verbatim language proposed by the Academy.
3. When the American Thyroid Association published a guideline on thyroid cancer that omitted any discussion of voice, laryngoscopy, or the recurrent laryngeal nerve, we created a multidisciplinary guideline emphasizing the role of laryngeal assessment and nerve monitoring in achieving optimal voice outcomes (2013 publication date).
4. When the American Board of Internal Medicine Foundation asked specialty societies to identify, as part of their *Choosing Wisely*® campaign, "five tests or procedures commonly used in their field, whose necessity should be questioned and discussed," we already had at our disposal numerous valid and actionable recommendations to choose from, based on our cadre of evidence-based clinical practice guidelines.
5. When the AMA Physician Consortium on Performance Improvement (PCPI) sought to develop evidence-based measures for adult sinusitis and acute otitis externa, they enlisted otolaryngology leadership to co-chair the development process and used guidelines developed by our Academy as the basis for defining standards in the Physician Quality Reporting System.

The Past

Just a decade ago, none of the above would have been possible. Otolaryngologists did not have a seat at the national quality table and our Academy lacked the clout that would come only from an established and innovative quality program. Our response to the above concerns would largely have been symbolic, with a forced reliance on non-otolaryngology groups and organizations to defend our interests. Serious guideline development was perceived as something we ultimately "had to do," but not necessarily what we would "want to do." A false hope prevailed that clinical indicators, evidence-based reviews, and practice parameters would somehow create a quality mirage among stakeholders. With pay for performance (P4P) looming, it did not take long for this mirage to be replaced by a largely reactive

acknowledgment that a serious quality program was sorely needed.

The Present

What a difference a decade makes. Our Academy has a thriving quality agenda and a state-of-the-art clinical practice guideline development program that has earned us not only a reserved seat at the national quality table, but also an international reputation for excellence. The Institute of Medicine and the Council for Medical Specialty Societies cited our guideline development manual, now in its third edition, as exemplifying best practice. Staff from our research, quality, and health policy business unit regularly teach, attend, and present at international venues.

Our membership and staff are empowered through educational opportunities that include miniseminars, instructional courses, the Guideline Task Force, the Cochrane Scholars program, a new Guideline International Network (G-I-N) Scholars initiative, and hands-on participation and leadership training in guideline development groups. We have partnered with the Cochrane ENT Disorders Group for member training and systematic literature searches, and with the Yale Center for Medical Informatics in an AHRQ-funded project on guidelines and decision support. As practice assessment becomes an increasingly important aspect of maintenance of certification (part IV), Academy-developed guidelines are defining the clinical metrics for performance.

The Future

Our success with guideline development has laid the foundation for similar success in the related areas of dissemination, implementation, and knowledge transfer. We are also well equipped to internalize performance measure development, a task currently handled by the AMA-PCPI, but soon to be outsourced to medical specialty societies.

Your Academy is well poised to develop quality products that promote best practice while preserving physician autonomy, which not only include multidisciplinary guidelines, but also encompass specialty-specific guidelines, clinical consensus statements, clinical indicators, and position (policy) statements. Efforts are under way to ensure our voice in the national dialogue integrating physician compensation with quality measures.

We have grown from a timid and defensive player in the quality arena to a proactive Academy that will provide its members with quality tools and measures to meet the demands of diverse healthcare stakeholders.

After a decade-long journey your Academy has emerged as a national quality leader, well ahead of many other professional medical societies, but with a limited portfolio of guidelines and measures. We now have the staff, processes, and leadership to forge ahead, but as a volunteer organization we cannot succeed without robust member engagement. There are many ways to get involved and have fun in the process. To express your interest and learn more about opportunities, please email Stephanie L. Jones, director of Research and Quality Improvement, at SLJones@entnet.org.

The New Marker of a Physician's Skill: Educating Community Via Our Outreach Campaigns

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

The history of medicine is highlighted by the pursuit of knowledge, dedication, and proficiency that marks the skills of the accomplished physician. Today, in the era of information, technology, and globalization, it is apparent that it is no longer sufficient for physicians to be reactive to the medical needs of their patients. We recognize the need for evidence-based medicine, practice guidelines, access to care, and preventative medicine. And community outreach, further extending knowledge and preventive care, is central to the success of modern medicine.

Community outreach simply means providing services to a population that does not typically have access to, or knowledge of, those services. It requires us to go out and identify what the population needs and bring it to them. Doctors need to rethink what service means. Traditionally, we thought in literal terms. It now means more than setting up clinics or providing health services in rural, urban, or underserved areas. It means more than providing top specialty care. The services we must provide are now much broader and more inclusive.

We must strive to educate our patients and ourselves so the patient and doctor are unified toward the same goals. We must educate our patients on health issues so they may be proactive in their healthcare. More effort needs to be spent on teaching patients the basics of what goes into a healthy lifestyle and understanding the elements of good medical care. Physicians are also looking at best practices and guidelines to improve outcomes. Patients need to understand access issues, whether it is simply navigating insurance options or seeking specialty care. More of us, patients and physicians alike, go to the Internet for information and guidance. We have a responsibility to make sure that information is accessible, accurate, and reliable.

Our Academy understands the importance of community outreach. This month's health observance is dedicated to Children's (Kids) E.N.T. Health. As you read through the articles in this month's *Bulletin*, I ask you to keep in mind the concept of community outreach. If you do, you will appreciate the wealth of information, efforts, and

activities promoted by the Academy designed to accomplish this task. The article on Clinical Practice Guidelines (CPG) not only gives us a heads-up on the upcoming revision of the CPG on tympanostomy and tubes in children, but also offers insight to the development and importance of guidelines. Careful reviews and recommendations, such as those described in the article on post-tonsillectomy analgesia, demonstrate how the dissemination of information not only can enhance our patient's experience and expectations, but may also save lives. This *Bulletin* introduces many learning opportunities. The Pediatric Webinars are one such exciting innovation that is already available on our website. Podcasts, such as the one on battery ingestion, are posted there, too.

I invite you to spend an hour or so on the Academy's recently updated website. As you surf through the myriad of information, keep community outreach in mind. After you log in and view the highlights of the homepage, go to the menu bar across the top of the page. There are a few areas that hold particular interest. Start by opening the Member page. Explore the Media Outreach section found at the bottom of the page. There you will find the Grassroots Media and Public Relations Handbook and monthly mini-campaigns. Each campaign features fact sheets and news template releases. You will find this month's Kids E. N. T. Health featured here, too. The next option on the bar is the Practice and Advocacy section. There you will find many interesting subjects, but I direct you particularly to the Information on Quality and Safety and the Guidelines and Policy Statements and Clinical Indicators sections.

Understanding and sharing these issues is central to good practice and good community outreach. Lastly, explore the Health Information link. The major areas of otolaryngologic care are presented. Under each title you will find information packaged in formats that are easily shared with your patients and the local media and available for your use. In the pediatric section you will find many items related to Kids E. N. T. Health, including the podcast on choking.

It is important to recognize the role you play in bringing outreach to the community. The physician is familiar to the patient, trusted, and recognized as a valuable resource. Enjoy this month's *Bulletin* and the Academy website; be creative and proactive with all the information available to you through our Academy and become a community outreach ambassador.

Clinical Practice Guidelines: Resources for Optimizing "Kids E.N.T." Practice

Kathleen Billings, MD
Assistant Professor, Division of Otolaryngology-Head and Neck Surgery
Ann and Robert H. Lurie Children's Hospital of Chicago
David E. Tunkel, MD
Director of Pediatric Otolaryngology
Johns Hopkins Medical Institutions

Clinical practice guidelines (CPGs) are excellent resources that bring evidence-based medicine to practicing clinicians and patients. A CPG, as noted by the Institute of Medicine (IOM), contains "statements that include recommendations intended to optimize patient care that are informed by systematic review of the evidence and an assessment of the benefits and harms of alternative care options."[1] CPGs summarize available evidence about specific clinical conditions, treatments, and procedures to help promote best practices with the use of action statements. They also identify areas for future research where evidence may be lacking.

The American Academy of Otolaryngology—Head and Neck Surgery Foundation (AAO-HNSF) has been a leader in CPG development since 2006, using experts in the field of otolaryngology, methodologists, experienced staff liaisons, allied health professionals, and selected additional stakeholders to create CPGs and clinical consensus statements. Recent CPGs address important aspects of otolaryngologic care for children.

The Guideline Development Taskforce (GDTF), first chaired by **Richard M. Rosenfeld MD, MPH,** and now by **Seth R. Schwartz, MD, MPH,** solicits, evaluates, and prioritizes topics for CPGs or clinical consensus statements. AAO-HNS/F committees, subspecialty societies, and even individual Academy Members can advance proposals for CPGs. CPGs have been published about management of cerumen impaction and acute otitis externa, topics certainly relevant to care of children with ear disease.[2,3] More recently, "Clinical Practice Guidelines for Tonsillectomy in Children," and "The Use of Polysomnography (PSG) for Sleep-disordered Breathing Prior to Tonsillectomy in Children" were published.[4,5] The tonsillectomy guideline emphasizes appropriate indications for children with recurrent throat infection and sleep-disordered breathing. Other key action statements present recommendations and supporting evidence about perioperative care for children undergoing tonsillectomy, including the use of antibiotics, steroids, and analgesics. The

action statements in the PSG guideline provide guidance for selection of children who benefit most from a PSG before tonsillectomy, and present indications for overnight monitoring after surgery for children with obstructive sleep disorders.

CPGs relevant to otolaryngology care have been developed by many organizations worldwide. In fact, the National Guideline Clearinghouse currently lists 81 guidelines under the search term "otorhinolaryngology" on its website, guidelines.gov, and many of these involve pediatric care issues. The IOM has emphasized the need for trustworthy CPGs, with recommendations for transparency in the development process, management of conflicts of interest, and inclusion of a broad group of stakeholders.[1]

The AAO-HNSF guideline task forces use a defined methodology to produce reliable guidelines with actionable statements. While the development process has been published in detail, key components of the process include a systematic evaluation of the available evidence in the literature, involvement of a broad

Social Media for Kids E.N.T. Health Month

The Academy plans to post the following messages on our social media sites. Share with your patients and add your own.

1. February is Kids E.N.T. Month, learn more: www.entnet.org/AboutUs/kidsENT.cfm
2. Learn more about Choking Hazards in children: www.entnet.org/AboutUs/kidsENT.cfm
3. Choking Hazards Campaign audio is now live, visit http://www.entnet.org/HealthInformation/Choking-Campaign.cfm for more information!
4. Share this information with your practice and the public by utilizing our draft template, learn more: www.entnet.org/AboutUs/kidsENT.cfm
5. Visit our Kids E.N.T. Health Library http://www.entnet.org/HealthInformation/pediatric.cfm
6. What to Expect after Your Child Has Tonsillectomy/Adenoidectomy Surgery: http://www.entnet.org/AboutUs/upload/Post-t-a-fact-sheet.pdf
7. Check out the Button Battery article in the February issue of the *Bulletin* (to be posted via social media)
8. See a re-post of this *Bulletin* article on Kids E.N.T. health online at: www.entnet.org/bulletin

group of stakeholders from multiple disciplines, an external review process, and a public comment period.[6]

The treatment of otitis media in children is the subject of two soon-to-be completed CPGs. The American Academy of Pediatrics (AAP) published a CPG for "Diagnosis and Management of Acute Otitis Media (AOM)," in 2004.[7] Statements in this CPG advanced the concept of initial management without antibiotics for children older than two years of age without severe disease. This AOM guideline has been updated by a committee of the AAP, and is scheduled for publication in early 2013. The observation option for children with AOM will be refined, based on results of recent clinical trials, and tympanostomy tubes are considered an option for prevention of AOM in otitis media-prone children.

The AAO-HNSF CPG on tympanostomy tubes in children is completing review, with publication expected during 2013. This CPG is timely, as tympanostomy tubes have been identified as an overused procedure, particularly for healthy children with short-term middle ear effusions. The tympanostomy tube CPG will discuss surgical indications for children with long-term effusions, and will provide action statements to guide surgical decision-making for children with recurrent AOM. The importance of identifying children who are at risk for developmental consequences of persistent OME will be emphasized. Several action statements will address care issues for children with indwelling tubes.

Clinical consensus statements have also been developed for topics where

high-level evidence does not exist to allow a full CPG, but where consensus can be developed to reduce variation in practices and improve care. A consensus statement about "Appropriate Use of Computed Tomography for Paranasal Sinus Disease," was published in November 2012.[8] Specific recommendations were made about timing and selection of imaging for children with sinus disease. This document may help reduce unnecessary exposure of children to ionizing radiation. A consensus statement on tracheostomy care was published in January of this year, and eight statements about children with tracheostomy are included.[9] We look forward to a pediatric chronic rhinosinusitis consensus statement that has been approved for development by the GDTF.

We must emphasize that a CPG is not a substitute for clinical judgment and does not serve as a protocol for all patients and clinical situations.[10] Healthcare providers and patients must be educated about CPGs, as awareness and adoption are as important as the development process. Finally, as healthcare advances and practices change, the CPGs must be revisited and perhaps revised to provide up-to-date optimal treatment. Additional information about clinical practice guideline development by the AAO-HNSF can be found at entnet.org/Practice/clinicalPracticeguidelines.cfm and www.entnet.org/Practice/upload/GDTF-Summer-2012-Newsletter_Final.pdf.

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Cosponsored Pediatric Otolaryngology Webinar Series Offered for CME Credit

Kenny H. Chan, MD
Chair, Foundation's Pediatric Otolaryngology Education Committee

The American Society of Pediatric Otolaryngology (ASPO) and the AAO-HNS Foundation (AAO-HNSF) are proud to offer a pediatric otolaryngology webinar series targeting practicing otolaryngologists who care for pediatric patients. These CME-approved activities are designed to address pertinent topics based on current clinical practice guidelines and expert opinion to address vital patient care concerns facing this target audience.

ASPO has been using the webinar format for more than two years as a medium to supplement didactic lectures for pediatric otolaryngology fellows across North America. As a second phase of this successful endeavor, ASPO wished to extend this learning opportunity to practicing physicians as well as residents and fellows. With this in mind, they approached the Foundation to partner with them and to serve as the continuing medical education provider. The two organizations entered into a joint sponsorship agreement to offer webinars in 2013 and 2014.

"The result of this collaboration is an outstanding example of the positive impact that organized medicine, leadership, and technology can have as we look to new and innovative ways to provide education," said **Joseph E. Kerschner, MD,** ASPO president. "Dr. Chan has led ASPO through this process in a masterful way and with the involvement of AAO-HNSF this project will have a lasting impact on pediatric otolaryngology education as we move to the future."

The purpose of the webinar series is to provide relevant pediatric otolaryngologic topics addressed by expert faculty using a robust webinar format. Richard M. Rosenfeld, MD, webinar faculty, explains "I am thrilled to participate in the Pediatric Otolaryngology webinar series and provide an update on otitis media.

The webinar format offers the advantages of both a polished, yet customized, slide presentation and a supplemental question and answer session tailored to the unique needs of the participants." The outcome objectives clearly spell out a systematic learning methodology based on evidence-based medicine. For each pediatric otolaryngologic disease process discussed, the participant will be expected to:

- evaluate the pathogenesis of the disease
- employ evidence-based medical treatment options
- compare the surgical options available and analyze the complications associated with each of the surgical options available

Ten prominent pediatric otolaryngology experts have been chosen as faculty for the 2013 series. Each presentation will be posted online allowing the registrants to view the presentations on their own schedule.

Craig S. Derkay, MD, presented the first webinar in January titled "Recurrent Respiratory Papillomatosis (RRP): Update 2013." The objective was to review the most recent literature regarding diagnosis, surgical treatment, and the use of adjuvant medications for children with RRP. An emphasis was placed on the future with a discussion of the potential influence the quadrivalent HPV vaccine could have on the next generation of children with RRP.

Marci Lesperance, MD, will present in November on the "Evaluation of Pediatric Sensorineural Hearing Loss." The goal of the presentation is to use real cases to illustrate how practicing otolaryngologists can assist their patients in understanding the cause of their hearing loss. The field of genetic hearing loss is a rapidly changing one and attendees will learn how to recognize common forms of genetic hearing loss and locate resources to learn more about genetic testing and syndromes.

"The Academy is pleased to collaborate with ASPO on this important education opportunity and is confident it will be a valuable education resource for ASPO and Academy members. It could also serve as a model for future partnerships with other societies," said **Sonya Malekzadeh, MD,** AAO-HNSF coordinator for Education.

The webinars are packaged so the registrant can enter into the series throughout the year. AAO-HNS and ASPO members receive a discounted registration fee of $695 for the entire 10-webinar series; non-member registration is $850 for the series. Registration details are available through www.aspo-cme.us.

A maximum of 10.0 AMA PRA Category 1 Credit(s)™ can be obtained through this education activity.

2013 Pediatric Otolaryngology Webinars

January	Craig Derkay, MD	Recurrent Respiratory Papillomatosis: Update 2013
February	Gresham Richter, MD	Diagnosis and Management of Vascular Malformations
March	Robert Naclerio, MD	Update on Allergic Rhinitis - A Burdensome Disease
April	Sally Shott, MD	Down Syndrome: Otolaryngologic Manifestations
May	Kenny Chan, MD	Evaluation and Management of Sialorrhea in Children
July	Margaret Kenna, MD	Hearing Tests and Hearing Aids: More Interesting Than You Thought
August	Hassan Ramadan, MD	Complications of Acute Rhinosinusitis in Children
September	Richard Rosenfeld, MD, MPH	Otitis Media Update
October	Kathy Sie, MD	Assessment and Management of Velopharyngeal Dysfunction
November	Marci Lesperance,MD	Evaluation of Pediatric Sensorineural Hearing Loss

Prevention of Injuries from Button Battery Ingestion in Children

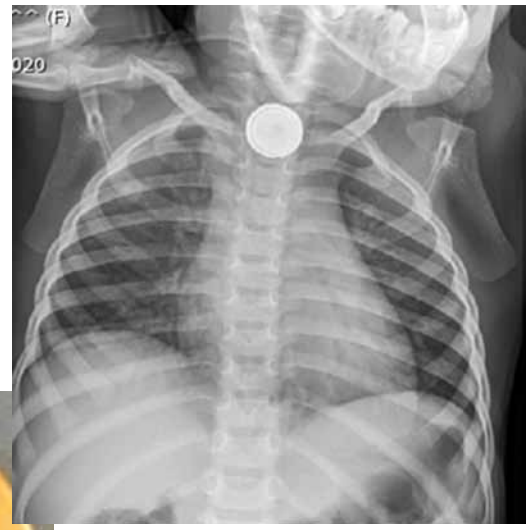
During the last decade, there has been a dramatic increase in the number of button battery ingestions and associated injuries in small children and infants. This is related to the growing use of large size (> 20 mm) lithium batteries in electronic devices. The batteries are now used in a wide range of devices, including remote controls, computers, musical greeting cards, and toys. The larger batteries, when ingested, will often lodge in an infant's or toddler's esophagus, and may create severe injury, including tissue necrosis, in just two hours. The combination of the children's easy access due to battery compartment security problems, larger battery size, and higher power voltage (3 V) leads to these severe injuries.

The most comprehensive data on button battery ingestion comes from cases reported to the National Battery Ingestion Hotline (NBIH) and nationwide U.S. Poison Control centers.[1-3] There are likely more than 3,000 ingestions each year. While most ingestions are benign as the batteries pass into the stomach and lower gastrointestinal system without incident, a smaller, but substantial number may lodge in the esophagus and cause severe injuries in a short time. These include minor burns, moderate injuries (esophageal strictures), major injuries (traumatic tracheal-esophageal fistula, vocal cord paralysis), and even death. Death is often related to direct erosion of the battery into the aorta with a massive hemorrhage. In fact, Litovitz reported in *Pediatrics* in 2010 on 221 minor, 74 moderate, 19 major, and one death from ingestion as reported to the National Poison Control Center in Washington, DC.[1] This trend has seen a 6.7 fold increase in the number of major or fatal injuries in the last 25 years. Otolaryngologists are often called to remove these batteries and treat the injuries. Since most severe injuries result from un-witnessed ingestions, prevention may be the best overall solution.

Button Battery Task Force

In 2012, the American Broncho-Esophagological Association (ABEA), led by President **Peter J. Koltai, MD,** in conjunction with the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) and the American Academy of Pediatrics (AAP), formed the Button Battery Task Force to address this problem. The Task Force, chaired by **Ian N. Jacobs, MD,** has representatives from multiple medical organizations and product safety experts. The task force aims to find solutions to the button battery problems using a multi-pronged approach, which includes:

1. Voluntary industry design standards
2. Public awareness and marketing
3. Development for funding activities
4. Legislative and regulatory support



The Task Force is working with industry on safer redesign as part of voluntary industry change. This includes working with battery makers, such as Energizer, on voluntary design changes to increase safety with safer batteries, better packaging, and improved labeling. On January 18, 2013, the Task Force met in Chicago with a number of key industry stakeholders to discuss solutions to the problem. It is also collaborating with Energizer and the AAP to develop public awareness materials intended to be displayed in pediatrician's offices, children's hospitals, and pediatric healthcare facilities across the country. Four current members of the Task Force, Toby Litovitz, MD; Kris R. Jatana, MD; Steve Krug, MD; and Don Mays, presented to the U.S. Consumer Product Safety Commission (CPSC) in March 2011. The Button Cell Battery Safety Act of 2011 (S.1165) that followed failed to advance in the 112th Congress. In September 2012, the Task Force met with legislators in Washington, DC, for early discussions on future political strategies and intends to have a meeting with the CPSC this spring to discuss future regulatory enforcements for areas of concern like compartment security. The ultimate goal is to decrease the incidence of button battery ingestion injuries with a multifaceted approach and change the lives of innocent children who come into contact with these devices.

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AMA Adopts Principles on Employed Physicians

Liana Puscas, MD
Chair, AAO-HNS Delegation to the AMA

The American Medical Association (AMA) House of Delegates conducted its 2012 Interim Meeting November 10-13.* One issue of importance to otolaryngologist-head and neck surgeons that was discussed was the adoption by the House of Delegates of general principles regarding employed physicians. Given the increasing numbers of otolaryngologists, these principles could help provide direction in the drafting of contracts. The following is a summary of the principles. A more detailed version of the principles can be found on the AMA website at www.ama-assn.org.

Principles for Employed Physicians

Conflicts of Interest

(a) Physicians should strive to recognize and address a conflict of interest that may exist between a physician's duties to his/her patients and to his/her employer.

(b) Employed physicians should be free to exercise their personal and professional judgment in voting and advocating on any matter regarding patient care interests, the profession, and healthcare without being retaliated against by their employers or being regarded in breach of their employment contracts.

(c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

(d) Physicians should always make treatment and referral decisions based on the best interests of their patients.

(e) Assuming a title or administrative position that may remove a physician from direct patient-physician relationships does not override professional ethical obligations.

Advocacy for Patients and the Profession

(a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the healthcare system or setting in which physicians practice, or the methods by which they are compensated.

(b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

Contracting

(a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with any healthcare entity as permitted by law and in accordance with the ethical principles of the medical profession.

(b) Physicians should never be coerced into employment with any healthcare entity and employment agreements between physicians and their employers should be negotiated in good faith.

(c) The employer should make clear to the physician the factors upon which compensation is based.

(d) Termination of an employment or contractual relationship between a physician and an entity employing the physician does not necessarily end the patient-physician relationship between the employed physician and persons under his or her care. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer.

(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause and should specify if termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges.

(f) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

(g) Physician employment agreements should contain dispute resolution provisions.

Hospital Medical Staff Relations

(a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements.

(b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

(c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting and advocating on any matter regarding medical staff matters without being deemed in breach of their employment agreements, nor be retaliated against by their employers.

(d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Peer Review and Performance Evaluations

(a) All physicians should promote and be subject to an effective program of peer review.

(b) Peer review should follow established procedures that are identical for all physicians practicing within a given healthcare organization, regardless of their employment status.

(c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians—not lay administrators—should be ultimately responsible for all peer review of medical services provided by employed physicians.

(d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings.

(e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician.

(f) Unless specified otherwise in the employment agreement, termination of employment should not automatically result in loss of medical staff membership or clinical privileges unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws.

Payment Agreements

(a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Also, there should be transparency regarding the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

(b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate, and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services if the violation is not the fault of the employee.

* Attendees of the meeting included the AAO-HNS Delegation to the House of Delegates: **Liana Puscas, MD,** delegation chair, and delegates **Michael S. Goldrich, MD, Shannon P. Pryor, MD,** and **Robert Puchalski, MD.** Alternate delegates, **Alpen A. Patel, MD,** and **David R. Nielsen, MD,** AAO-HNS EVP/CEO, were also in attendance. Joy Trimmer, JD, senior director for AAO-HNS Government Affairs provided staff support. For more information, please contact govtaffairs@entnet.org.

Save the Date for the 2013 BOG Spring Meeting & OTO Advocacy Summit

Mark your calendar for the 2013 Board of Governors (BOG) Spring Meeting & OTO Advocacy Summit May 5-7, in Alexandria, VA, and Washington, DC. This year's BOG Spring Meeting and Summit will provide many great opportunities for attendees to hear from experienced policymakers, participate in committee meetings, receive "insider" briefings, and take advantage of pre-scheduled visits with Members of Congress and/or their staffs on Capitol Hill. There will also be ample networking events and an exclusive ENT PAC fundraiser. Registration for both the BOG Spring Meeting and the OTO Advocacy Summit will open this month! Additional information is available at www.entnet.org/BOG&Summit. Mark your calendar today, we look forward to seeing you in May!

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 webpage, you can learn more about the issues affecting 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.

ENT PAC

The Political Action Committee of the American Academy of Otolaryngology–Head and Neck Surgery, Inc.

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 non-partisan, 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).

Recent Legal Challenges to State Medical Liability Caps

Each year, there are a number of legal challenges and proposed changes to existing medical liability statutes. The AAO-HNS, working with other state and national medical societies, tracks and advocates for comprehensive medical liability reforms at the federal and state levels. One of the most contentious issues each year is caps on damages, particularly caps on non-economic damages often referred to as "pain and suffering" awards.

Caps on damages are an essential element to comprehensive medical liability reform as they often provide stability to a tenuous legal environment. Nearly 30 states have enacted some form of a cap on damages in medical liability actions. However, the amount of the cap and the type of damages covered varies widely depending on the state.

In addition to the legislative proposals introduced and debated each year on medical liability reform, there are also a number of legal challenges. In recent years, there have been at least 15 states where the courts upheld a cap on damages and at least 10 states that have overturned caps as unconstitutional. In 2012, there were major constitutional challenges to caps in Kansas and Missouri, where the decisions on medical liability caps were split.

On October 5, 2012, the Kansas Supreme Court, in a 5-2 decision, upheld that a $250,000 cap on non-economic damages is constitutional in medical liability cases. This was the second time that the Kansas Supreme Court has upheld the cap. The Court found that the legislature's decision to enact the cap was rationally related to a valid legislative purpose, and as such, was constitutional.

The Court found that the intent of the cap was to ensure quality healthcare availability and to promote affordable liability insurance for healthcare professionals. These objectives were recognized by the Court as a legitimate state interest that promotes the general welfare of its citizens. This analysis was based on the fact that physicians, hospitals, and other healthcare professionals are required by law to carry liability insurance and participate in the Health Care Stabilization Fund, which together, provide a guaranteed source of recovery for patients injured through medical negligence. The Court considered this as a "quid pro quo," wherein individuals give up the right to recover unlimited non-economic damages in return for an assured source of recovery.[1]

Prior to the decision in Kansas, the Missouri Supreme Court had struck down a state law that capped non-economic medical liability awards at $350,000. In a 4-3 decision, the Court ruled that caps on non-economic damages were unconstitutional because they deprive patients of their right to trial by jury, which includes the right to have a jury set damages.[2] The caps were part of a tort reform package that passed the Missouri legislature in 2005. The Missouri Medical Association has expressed its disappointment in the decision and has indicated that restoring the caps will be a priority for the 2013 legislative session.

> "The Court found that the intent of the cap was to ensure quality healthcare availability and to promote affordable liability insurance for healthcare professionals."

Another notable legal challenge this year involved a total cap on damages. In March 2012, the Supreme Court of Louisiana upheld the state's $500,000 limit on total medical liability damages by declaring the cap constitutional.[3]

If history repeats itself, additional legal challenges to caps on damages will likely arise in 2013. The AAO-HNS will continue to closely track such court challenges and medical liability reform proposals during the state legislative sessions. For more information, email AAO-HNS State Legislative Affairs at legstate@entnet.org. In addition, to receive timely updates on state, federal, or grassroots initiatives, AAO-HNS members are encouraged to join the ENT Advocacy Network—a free member benefit. To join, email govtaffairs@entnet.org.

References

1. Miller v. Johnson, No. 99,818, 2012 WL 4773559 (Kan. Oct. 5, 2012).
2. Watts v. Lester E. Cox Medical Centers, 376 S.W.3d 633 (Mo. 2012).
3. Oliver v. Magnolia Clinic, et al., 85 So3d 39 (La. 2012).

Increase Your Involvement with AAO-HNS/F in 2013!

Call For Open Leadership Positions

AAO-HNS/F Seeks Chair for Ethics Committee

AAO-HNS/F Boards of Directors are seeking applications for the position of Chair of the AAO-HNS/F Ethics Committee. The elect position would be October 1, 2013, through September 30, 2014. The actual term of four years would begin October 1, 2014, with a possible two-year extension at the discretion of the Executive Committee.

The Ethics Committee assists the Boards of Directors in fulfilling their oversight responsibilities with respect to

(1) development and enforcement of the Code for Interactions with Companies and the Code of Ethics;

(2) the management of potential conflicts of interest;

(3) the oversight of policy recommendations regarding ethical issues to the Boards of Directors for their action; and

(4) upholding the procedural guidelines for the AAO-HNS disciplinary proceedings.

The ideal candidate will be a practicing otolaryngologist who has or is serving on the Ethics Committee.

For more information and a detailed job description, visit **http://www.entnet.org/AboutUs/boardsofDirectors.cfm**.

Interested candidates should submit a CV and cover letter to Caitlin Couture at **ccouture@entnet.org** by March 1, 2013.

AAO-HNSF Seeks Coordinator for Research and Quality Improvement

A search is underway for the Coordinator for Research and Quality Improvement of the Foundation. The elect position would be October 1, 2013 through Sept. 30, 2014, with the actual term of four years beginning October 1, 2014.

The position provides oversight of research and evidence-based activities that improve care – this includes treatment effectiveness and outcomes, efficiency, patient safety and quality, as well as activities that assist members with education and opportunities to improve performance in practice and translational research. The Coordinator will oversee the activities of the Research Advisory Board (RAB), and the Advisory Council on Quality (ACQ). Chairs of these two bodies will interface and provide expertise to the Research and Quality Improvement Coordinator on the research and quality agendas. The Coordinator will also act as a consultant to the SocioeconomicCoordinator for issues relating to quality and payment.

Specific duties of the Coordinator include facilitating Foundation research and quality/patient safety efforts, through input from the RAB and ACQ and the relevant content committees: Patient Safety Quality Improvement (PSQI), Outcomes Research and Evidence Based Medicine (OREBM), Guidelines Task Force (GTF), and CORE grants.

For more information and specific candidate criteria, visit **http://www.entnet.org/AboutUs/boardsofDirectors.cfm**.

Interested candidates should submit a CV and cover letter to Jean Brereton at **jbrereton@entnet.org** by March 1, 2013.

AAO-HNSF Seeks Editor in Chief

Otolaryngology–Head and Neck Surgery, the official journal of the American Academy of Otolaryngology–Head and Neck Surgery Foundation, is seeking applications for the position of Editor in Chief. The elect position would be October 1, 2013, through September 30, 2014. The actual term of four years would begin October 1, 2014, with the possibility of renewal for an additional four-year term.

The Editor in Chief must be experienced with peer review and comfortable with new publishing technologies. He or she will be responsible for the scientific content of the journal; selection of associate editors and editorial board members; enhancement of the journal's high standards for authoritative, innovative, top quality research; identification of emerging areas of importance and solicitation of content from these areas; oversight of peer review of all papers submitted to the journal; and annual editorial board meetings.

For more information and specific candidate criteria, visit **http://www.entnet.org/educationandresearch/journal.cfm.**

Interested candidates should submit a CV and cover letter to Eileen Cavanagh at **ecavanagh@entnet.org**. The deadline for receipt of completed applications is March 15, 2013.

Policy Statement Updates

The Academy currently reviews all of their policy statements on a rolling three year basis. We commenced a new review cycle in September of 2012 and are continuing to request Academy Committees' assistance in making sure that the policy content is up to date.

Rationale for Review:

- This review is needed because the Policy Statements have not been reviewed for several years.
- The Physician Payment Policy (3P) Workgroup and Health Policy team are committed to ensuring these statements are updated and useful for members.
- The Policy Statements for your review are those that are directly relevant to your expertise.

Background:

- The Academy provides guidance to members through several different means including Clinical Practice Guidelines, Policy Statements, Clinical Indicators, CPT for ENT coding articles, and private payer appeal letter templates.
- Policy statements are generated from within AAO-HNS/F Committees. There are multiple reasons why Policy Statements are created, including: as a response to a payer payment action; to publicize our position to support a procedure for use in advocacy efforts with state and federal regulatory and federal policy or law; or to clarify the Academy's position on certain practices within the specialty.

Update Process:

- We have divided the policy statements into three tiers for three separate rounds of review over the course of a year (September 2012 through September 2013) taking multiple factors into account for priority including how outdated each statement is, concurrent ongoing research and guideline development, and utilization of each. After prioritization, each is assigned to clinical committee of corresponding expertise for review and update.

Round 1:

- After an extensive first round review process by AAO-HNS Committees, the Executive Committee, and Board of Directors, the Academy has reaffirmed nine policy statements and revised 11. A new statement on Tongue Suspension was also released in December.
- The updates along with the new statement can be found on the Academy website as designated below. We have the revised policy statements in this article.

Ambulatory Procedures—UPDATED

The American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS) recognizes the existence of lists of surgical procedures that may be appropriately performed in an ambulatory surgical center (ASC) setting. The AAO-HNS does not develop or provide these lists of otolaryngologic procedures to the Centers for Medicare and Medicaid Services (CMS), however the Academy does support general standards for services covered in the ASC setting set forth in the Federal Register, Vol. 77, page 45159, July 30, 2012, and listed below:

Under §416.2 and §416.166 of the regulations, subject to certain exclusions, covered surgical procedures are surgical procedures that are separately paid under the Outpatient Prospective

Policy Statement	Date Revised or Reaffirmed on 12/8/12
Ambulatory Procedures	Revised
Botulinum Toxin Treatment	Revised
Debridement of the Sinus Cavity after ESS	Revised
Dilation of the Sinuses, any method (e.g., balloon, etc.)	Reaffirmed
Foreign Bodies of the Upper Aerodigestive Tract	Revised
Head and Neck Surgery	Revised
Hearing Aids	Reaffirmed
Implantable Hearing Devices	Revised
Intra-Operative Use of Computer Aided Surgery	Reaffirmed
Medical Role of Cerumen Removal	Reaffirmed
Micropressure Therapy	Revised
Minimal Test Battery for Cochlear Implants	Reaffirmed
Nasal Surgery and OSAS	Revised
Physician Drug Dispensing	Reaffirmed
Sinus Endoscopy	Reaffirmed
Submucosal Ablation of the Tongue Base for OSAS	Reaffirmed
The Roles of Flexible Laryngoscopy Videostroboscopy	Revised
Treatment of Obstructive Sleep Apnea	Revised
Uvulapalatopharyngoplasty	Reaffirmed
Voice Therapy in the Treatment of Dysphonia	Reaffirmed
AAO-HNS Fact Sheet: Cochlear Implants and Meningitis Vaccination	Revised

Payment System (OPPS), that would not be expected to pose a significant risk to beneficiary safety when performed in an ASC, and that would not be expected to require active medical monitoring and care at midnight following the procedure ("overnight stay").

It is important to note that there are numerous exclusions to covered services in the ASC setting that are outlined under 42 CFR §416.166 and listed below:

General exclusions. Notwithstanding paragraph of this section, covered surgical procedures do not include those surgical procedures that—

1. Generally result in extensive blood loss;
2. Require major or prolonged invasion of body cavities;
3. Directly involve major blood vessels;
4. Are generally emergent or life-threatening in nature;
5. Commonly require systemic thrombolytic therapy;
6. Are designated as requiring inpatient care under § 419.22(n) of this subchapter;
7. Can only be reported using a CPT unlisted surgical procedure code; or
8. Are otherwise excluded under § 411.15 of this subchapter.

Botulinum Toxin Treatment—UPDATED

Section I. Treatment of Spasmodic Dysphonia (Laryngeal Dystonia)

The American Academy of Otolaryngology—Head and Neck Surgery, Inc. ("AAO-HNS") considers Botulinum toxin a safe and effective modality for the treatment of spasmodic dysphonia and it may be offered as primary therapy for this disorder.

Section II. Botox Treatment for Other Head And Neck Dystonias

A. Blepharospasm

The AAO-HNS considers botulinum toxin a safe and effective modality for the treatment of blepharospasm and it may be offered as a primary form of therapy. Botulinum toxin has been approved as a safe and effective treatment of blepharospasm by the FDA.

B. Cervical Dystonia (Spasmodic Torticollis)

The AAO-HNS considers botulinum toxin a safe and effective modality for the treatment of cervical dystonia. There is some controversy as to whether botulinum toxin or pharmacotherapy should be offered as primary therapy. The benefit from botulinum toxin outweighs that of pharmacotherapy in many cases, certainly for the treatment of rotational cervical dystonia, or cervical dystonia associated with severe pain. In cases where there is inadequate response with pharmacotherapy, or there are intervening side effects, treatment with botulinum toxin may be offered.

C. Orolinguomandibular Dystonia

1. The AAO-HNS states that local injections of botulinum toxin into the masseter and temporalis muscles for jaw-closing, and pterygoid and digastic muscles for jaw-opening dystonia is established as a safe and effective modality for managing this disorder.
2. Considering the difficulty of the procedure in treating complicated jaw deviations and jaw opening, this form of treatment is limited to patients who have failed more conservative therapies. However, the benefit has been dramatic for some in this select group. Use of botulinum toxin for jaw-opening and deviation dystonia, injecting toxin into the pterygoid and digrastic muscles is promising, but additional experience is needed.
3. Lingual dystonia may be effectively treated with botulinum toxin, but there is a significant risk of dysphagia. Botulinum toxin therapy is investigational for this indication.

D. Hemifacial Spasm (HFS) and/or Synkinesis

The AAO-HNS considers local injections of botulinum toxin into facial muscles a safe and effective modality in treating hemifacial spasm and/or synkinesis. This modality of therapy may be offered as primary therapy in managing the condition. Botulinum toxin can be particularly helpful in treating synkinesis to reestablish facial symmetry following a facial nerve paralysis.

E. Neurogenic Laryngeal Stridor

The AAO-HNS considers local injections of botulinum toxin into laryngeal muscles an effective modality in treating neurogenic laryngeal stridor. This modality of therapy may be offered as primary therapy in managing the condition. While it is generally very safe, the nature of the disorder and the potential contributing problems such as stridor and aspiration should be considered in its case.

F. Frye's Syndrome

Botulinum toxin can be applied to patients for treatment of Frye's Syndrome and gustatory sweating related to autonomic dysfunction.

Section III. Treatment of Other Conditions

A. Facial Dynamic Rhytids

Botulinum toxin can be applied to patients for the treatment of dynamic and hyperkinetic facial lines and furrows.

B. Recalcitrant Hyperfuntional Voice Disorders

Botulinum toxin can be injected for management of recalcitrant muscular tension dysphonia, mutational dysphonia, and other hyperfunctional voice disorders (i.e., vocal fold granulomas or traumatic mucosal injury) that do not resolve with more traditional voice therapy methods and other more conservative medical measures.

C. Cricoppharyngeus Muscle Hypertonicity

In select patients, botulinum toxin may be useful in the treatment of dysphagia due to hypertonicity of the cricopharyngeus muscle. Botulinum toxin can also be applied to patients with post-laryngectomy cricopharyngeus muscle hypertonicity causing difficulty with the use of voice prostheses.

Debridement of the Sinus Cavity after ESS—UPDATED

Debridement of the sinus cavity is a procedure commonly performed following endoscopic sinus surgery (ESS). It involves transnasal insertion of the endoscope for visualization and parallel insertion of various instruments for

the purpose of removal of postsurgical crusting, residua of dissolvable spacers, coagulum, early synechiae, or devitalized bone or mucosa. It may also be utilized to remove crusts or debris in patients with longstanding chronic sinusitis with persistent sinonasal inflammation who have undergone sinus surgery in the past. It is performed under local or general anesthesia in a suitably equipped office or operating room, depending on the clinical circumstances of the case.

It is the position of the Academy that postoperative debridement aids healing and optimizes the ability to achieve open, functional sinus cavities. This also facilitates optimal instillation of topical therapies and saline irrigations, long-term disease surveillance, and endoscopically-derived cultures.

Similar improvement in control of inflammation and secondary infection is obtained by debridement in other subtypes of chronic sinusitis patients; particularly in recurrent/persistent bacterial infections and/or fungal sinusitis. Debridement may also be required in patients with chronic crusting in the setting of previous endoscopic tumor surgery and/or paranasal sinus radiation.

The frequency with which the above mentioned procedure should be performed is a clinical judgement best made by the surgeon and determined on a case-by-case basis, with the patient's clinical interests as the criteria of need. Setting an arbitrary limit on the number of debridements does not account for variability between patients in the healing process or severity of disease and can significantly jeopardize the quality of care that patients receive and negatively affect the overall outcome of ESS.

The Medicare fee schedule, the source for the concept of global periods, clearly assigns zero follow-up days to the 31237 code and most ESS procedures (several have a 10 day period: 31239 and 31290-31294). The reason for this assignment is that in the initial formulation of the relative value units for ESS, need for debridement of the sinus cavity was noted to vary greatly depending on the individual surgical case. ESS relative value units were developed with this exclusion of debridements factored into their overall weight: ESS code values do not include the work, risk, judgement, and skill necessary for this separate procedure.

Medicare work values assigned to the various codes for ESS took into account all of these factors. Haphazardly assigning lower work-valued codes in the place of 31237 as well as tampering with the Medicare global periods assigned, leads to the skewing of several of the key elements that were arrived at to produce fairness and equitable payments for the work done. This results in incorrectly lowered payments, inconsistent with the level, volume, and intensity of the work performed.

Insurance companies that profess to use Medicare approaches to reimbursements should use all of the critical elements of those formulations to be consistent with the work values and payment rules inherent in the Medicare concepts mentioned.

Sinus surgery is unilateral in nature as are debridements done thereafter. Payments for these procedures should be also. Adopted 10-18-12 Guidelines are not a substitute for the experience and judgment of a physician and are developed to enhance the physicians' ability to practice evidence-based medicine.

Foreign Bodies of the Upper Aerodigestive Tract—UPDATED

Board certified members of the American Academy of Otolaryngology—Head and Neck Surgery, by virtue of their training, are qualified to manage foreign bodies of the upper aerodigestive tract in adults and children. Whenever experienced physicians, appropriately trained support personnel, properly sized equipment, and appropriate post-surgical patient care are available, these cases should ideally be managed at the closest available facility.

Head and Neck Surgery—UPDATED

To become board certified, an otolaryngologist has to complete a rigorous training program. Following one year training in general surgery, an additional five years of residency training in otolaryngology-head and neck surgery is required to be considered eligible to apply to sit for the specialty board examination in otolaryngology. During the training years, residents in otolaryngology-head and neck surgery should learn to manage the full spectrum of benign and malignant disorders involving the head and neck while also learning techniques of facial plastic and reconstructive surgery.

Implantable Hearing Devices—UPDATED

The American Academy of Otolaryngology—Head and Neck Surgery, Inc. considers the implantation of a percutaneous or transcutaneous bone conduction hearing device, placement of a bone conduction oral appliance, and implantation of a semi-implantable or totally implantable hearing device to be acceptable surgical procedures for the relief of hearing impairment when performed by a qualified otolaryngologist-head and neck surgeon or other qualified healthcare professional. Use of any device must adhere to the restrictions and guidelines specified by the appropriate governing agency, such as the Food and Drug Administration in the United States and other similar regulatory agencies in countries other than the United States.

Micropressure Therapy—UPDATED

The Equilibrium Committee of the American Academy of Otolaryngology—Head and Neck Surgery and the Board of Directors of the American Academy of Otolaryngology—Head and Neck Surgery have reviewed the literature with respect to micropressure therapy for Meniere's disease.

We find that there is convincing and well-controlled medical evidence to support the use of micropressure therapy (such as the Meniett device) in certain cases of Meniere's disease. Micropressure therapy can be used as a second level therapy when medical treatment has failed. The device represents a largely non-surgical therapy that should be available as one of the many treatments for Meniere's disease.

Nasal Surgery and OSAS—UPDATED

Nasal surgery is a beneficial modality for the treatment of obstructive sleep apnea (OSA).

Nasal surgery can facilitate the treatment of OSA using CPAP (Continuous Positive Airway Pressure). Nasal resistance or obstruction is highly related to CPAP non-acceptance where for each 0.1 Pa/cm3/s increase in resistance the odds ratio of non-acceptance increases 1.48 fold (Sugiura 2007, level 2). Nasal surgery lowers nasal resistance and Nakata & coworkers (2005, level 3) showed that using septoplasty and inferior turbinate reduction for CPAP non-adherent patients, there was a reduction in nasal resistance from 0.57 to 0.16 Pa/cm3/s and post-operatively, all patients became CPAP adherent. Nasal surgery may lower CPAP pressures by 2-3cm H2O in level 4 studies (Friedman 2000, Zonato 2006)

Nasal surgery may facilitate the treatment of OSA using oral appliances. Non-responders to oral appliance therapy have higher nasal resistance compared with responders (Zeng 2008, level 2). Similarly, in a study of 630 patients treated with mandibular advancement devices (Marklund 2004, level 2), women with complaints of nasal obstruction had an odds radio for successful treatment of only 0.1. Since nasal surgery lowers nasal airway resistance, oral appliance therapy may be facilitated in subjects with nasal obstruction.

Nasal surgery can improve quality of life in patients with sleep apnea in level 3 & 4 studies. With nasal surgery, the Epworth Sleepiness Scale (ESS), has been shown to decline from levels associated with excessive sleepiness (>=10) to levels consistent with normal function (Verse 2002, Nakata 2005, Li 2008). SF-36 scores of OSA patients significantly improved in the role physical, emotional, vitality, social functioning, generic health and mental health domains, following nasal surgery (Li 2008).

Nasal surgery as the sole intervention effectively treats OSA in a subset of patients. The overall success rate is about 17 percent for Apnea hypopnea index reduction of 50 percent and to less than <20/hour, as summarized in a review by Verse & coworkers (2003). This is based on case series studies cited in Verse (2003), Morinaga (2009) Series (1992), and in a randomized, placebo controlled study by Koutsourelakis (2008).

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The Roles of Flexible Laryngoscopy / Videostroboscopy—UPDATED

The Roles of Flexible Laryngoscopy Videostroboscopy in the Office Evaluation and Management of Patients with Otolaryngologic Disorders.

Flexible and telescopic diagnostic laryngoscopy (31575) and flexible and/or rigid videostroboscopy (31579) are well established diagnostic procedures that are medically indicated for the diagnosis of voice, swallowing, and airway disorders. Each procedure requires the application of distinct endoscopy skills, training and judgment. These endoscopic procedures offer unique information in the functional and anatomic assessment of the upper airway. In most cases, these examinations can be performed in the office without taking the patient to the operating room or the endoscopy suite. These procedures are effective in diagnosis and management of otolaryngologic disorders and they are not investigational. Some patients may require one or more of these diagnostic procedures performed individually or sequentially. The extended nature of examination of the structure and function of the upper aerodigestive tract is often comprehensive

and complex. The endoscopic evaluation of the upper airway should not be considered part of the routine office examination.

- Flexible laryngoscopy or videostroboscopy should not be considered a routine part of an office visit.
- Flexible laryngoscopy or videostroboscopy should not be required to be done as a separate return visit.
- Flexible laryngoscopy or videostroboscopy should not be mandated to be performed in a separate endoscopy suite or outpatient surgery center in order to be reimbursed.

Clearly defined clinical indicators based on ICD-9 diagnostic code groups have been developed in the literature to support the above positions.

Treatment of Obstructive Sleep Apnea—UPDATED

Treatment of Obstructive Sleep Apnea—Overview

Obstructive Sleep Apnea (OSA) is a common disorder involving collapse of the upper airway during sleep. This repetitive collapse results in sleep fragmentation, hypoxemia, hypercapnia, and increased sympathetic activity. As specialists in upper airway anatomy, physiology, and surgery, otolaryngologists are uniquely qualified to treat patients with OSA. In the *Clinical Guidelines for Evaluation, Management and Long-term Care of Obstructive Sleep Apnea in Adults*, it is recommended that evaluation for primary surgical treatment be considered in select patients who have severe obstructing anatomy that is surgically correctible (e.g., tonsillar hypertrophy obstructing the pharyngeal airway) and in patients in whom continuous positive airway pressure (CPAP) therapy is inadequate (Epstein EJ, Evidence Based Clinical Guideline).

Surgical treatment of pediatric sleep-disordered breathing with tonsillectomy and adenoidectomy is the recommended first-line treatment. In the pediatric population, resolution of OSA occurs in 82 percent of patients who are treated with tonsillectomy and adenoidectomy (Breitzke, S, Meta-analysis). Another recent publication of specific interest for otolaryngologists is a large multicenter retrospective review on the treatment outcomes for OSA after an adenotonsillectomy. This review included 578 children of which 90 percent of the children were younger than 13 years of age. Fifty percent of the children were obese (BMI > 95 percent). Only 27 percent of the children had complete resolution of OSA (AHI < 1 total sleep time) while 21.6 percent had an AHI>5/hr TST. Surgical success was variable and depended upon outcome measures selected. So success is as low as 27 percent (AHI of < 1) or as high as 78 percent (AHI <5). Fifty nine percent of the obese children had an AHI>5/hr TST. An analysis of factors that were associated with an elevated post-operative AHI in order of influence were older than seven years, elevated BMI, presence of asthma, and more severe OSA pre-operatively.

In most patients with moderate to severe OSA, continuous positive airway pressure (CPAP) is the first line treatment. Successful long-term treatment of OSA with CPAP is difficult to achieve and fewer than 50 percent of patients on CPAP are adequately treated, as defined by four hours of use 70 percent of nights (Weaver, TE, Level 2 evidence and Kribbs, NB, Level 2 evidence). Other treatment options must be available to patients with OSAS.

Surgical procedures may be considered as a secondary treatment for OSA when the outcome of PAP therapy is inadequate, such as when the patient is intolerant of CPAP, or CPAP therapy is unable to eliminate OSA (Consensus). Surgery may also be considered as a secondary therapy when there is an inadequate treatment outcome with an oral appliance (OA), when the patient is intolerant of the OA, or the OA therapy provides unacceptable improvement of clinical outcomes of OSA (Consensus). Surgery may also be considered as an adjunct therapy when obstructive anatomy or functional deficiencies compromise other therapies or to improve tolerance of other OSA treatments (Consensus)(Epstein, EJ). Surgery for OSAS has been shown to improve important clinical outcomes including survival and quality of life (Weaver, EM. Level 2 evidence).

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Cochlear Implants and Meningitis Vaccination—UPDATED

What you should know

- Children with cochlear implants are more likely to get bacterial meningitis than children without cochlear implants. In addition, some children who are candidates for cochlear implants have inner ear anatomic abnormalities that may increase their risk for meningitis.
- Because children with cochlear implants are at increased risk for pneumococcal meningitis, the Centers for Disease Control (CDC) recommends that they receive pneumococcal vaccination on the same schedule that is recommended for other groups at increased risk for invasive pneumococcal disease. Recommendations for the timing and type of pneumococcal vaccination vary with age and vaccination history and should be discussed with a healthcare provider.
- The Centers for Disease Control and Prevention (CDC) has issued pneumococcal vaccination recommendations for individuals with cochlear implants. These recommendations can be viewed in detail on the CDC website: (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5909a2.htm).
  - Children who have cochlear implants or are candidates for cochlear

implants should receive PCV13. PCV13 is now recommended routinely for all infants and children (see Table 2 in the CDC March 12, 2010 MMWR issue located at the above website for the number of doses and dosing schedule).
- Older children with cochlear implants (from age two years through age five) should receive two doses of PCV13 if they have not received any doses of PCV7 or PCV13 previously. If they have already completed the four-dose PCV7 series, they should receive one dose of PCV13 through age 71 months.
- Children six through 18 years of age with cochlear implants may receive a single dose of PCV13 regardless of whether they have previously received PCV7 or the pneumococcal polysaccharide vaccine (PPSV23) (Pneumovax®).
- In addition to receiving PCV13, children with cochlear implants should receive one dose of PPSV23 at age two years or older and after completing all recommended doses of PCV13.

- The Centers for Disease Control and Prevention (CDC) has issued pneumococcal vaccination recommendations for adults with cochlear implants. These recommendations can be viewed in detail on the CDC website: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6140a4.htm.
  - Adult patients (≥19 yrs of age) who are candidates for a cochlear implant and those who have received a cochlear implant should be given a single dose of PCV13 followed by a PPSV23 at least eight weeks later. A second dose of PPSV23 is recommended for those 65 years old and older.
  - For those adults who previously have received ≥1 doses of PPSV23 should be given a PCV13 dose ≥1 year after the last PPSV23 dose was received. For those who require additional doses of PPSV23, the first such dose should be given no sooner than eight weeks after PCV13 and at least five years after the most recent dose of PPSV23.
  - For both children and adults, the vaccination schedule should be completed at two weeks or more before surgery.

Additional Facts

- According to the Food and Drug Administration (FDA), as of April 2009, approximately 188,000 people worldwide have received cochlear implants. In the United States, roughly 41,500 adults and 25,500 children have received them. In the U.S., there are 122 known reports of meningitis in patients who have received cochlear implants with 64 percent of these cases having occurred in children.
- Meningitis is an infection of the fluid that surrounds the brain and spinal cord. There are two main types of meningitis, viral and bacterial. Bacterial meningitis is the more serious type and the type that has been reported in individuals with cochlear implants. The symptoms, treatment, and outcomes may differ depending on the cause of the meningitis.
- The vaccines available in the United States that protect against most bacteria that cause meningitis are:
  - 13-valent pneumococcal conjugate (PCV13) (Prevnar 13®)
  - 23-valent pneumococcal polysaccharide (PPSV) (Pneumovax®)
  - Haemophilus influenzae type b conjugate (Hib)
  - Tetravalent (A, C, Y, W-135) meningococcal conjugate (Menactra® and Menveo®)
  - Tetravalent (A, C, Y, W-135) meningococcal polysaccharide (Menomune®)
- Meningitis in individuals with cochlear implants is most commonly caused by the bacterium Streptococcus pneumoniae (pneumococcus). Children with cochlear implants are more likely to get pneumococcal meningitis than children without cochlear implants.
- There is no evidence that children with cochlear implants are more likely to get meningococcal meningitis, caused by the bacterium Neisseria meningitides, than children without cochlear implants. Healthcare providers should follow the CDC immunization guidelines for routine meningococcal vaccination.
- The Haemophilus influenzae type b (Hib) vaccine is not routinely recommended for those five years old or older, since most older children and adults are already immune to Hib. Available information does not suggest that older children and adults with cochlear implants require the Hib vaccine. However, the Hib vaccine can be given to older children and adults who have never received it. Children younger than age five should receive the Hib vaccine as a routine protection, according to the CDC guidelines for childhood immunizations. Most children born after 1990 have received the Hib vaccine as infants.
- Healthcare providers (family physicians, pediatricians, and otolaryngologists) and families should review the vaccination records of current and prospective cochlear implant recipients to ensure that all recommended vaccinations are up to date

After beginning in the Fall of 2012 with a review of those policies which were the most out of date and most highly utilized first, we have progressed to the second round of review. In 2013, the Academy will be continuing to request Academy Committees' assistance for second and third round reviews to ensure that the policy content is up to date. If you have any questions regarding the policy statement update process, please email healthpolicy@entnet.org.

The Academy would like to extend a special thank you to the hard work of the following committees for contributing their clinical expertise during the first round of policy statement reviews:

The Physician Payment Policy Workgroup (3P)
The Airway and Swallowing Committee
The Equilibrium Committee
The Head and Neck Surgery Education Committee
The Hearing Committee
The Imaging Committee
The Implantable Hearing Devices Committee
The Medical Devices and Drugs Committee
The Pediatric Otolaryngology Committee
The Plastic and Reconstructive Surgery Committee
The Rhinology and Paranasal Sinus Committee
The Sleep Disorders Committee
The Voice Committee

CMS 2013 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment Final Rule: What Academy Members Need to Know

OPPS 2013 Final Payment Rates

In the final rule, CMS finalized a hospital outpatient conversion factor rate increase of 1.8 percent, increasing the conversion factor from $70.170 in 2012 to $71.313 in 2013. This was due to an updated estimate of the market basket increase of 2.6 percent and an updated MFP adjustment of -0.7 percent minus the required .1 percent. CMS has also finalized the statutory -2 percent reduction in payments for hospitals that fail to meet the hospital outpatient quality reporting (OQR) requirements.

Updates Affecting OPPS Payments

For CY 2013, CMS has finalized the use of the geometric mean cost of services within an Ambulatory Payment Classification (APC) to determine relative payment weights for services. This is a drastic change from the former methodology, used since the inception of the OPPS in 2000, which relied on the median costs of services to establish relative weights for services. CMS states that this change is in response to commenters' persistent concerns regarding the degree to which payment rates reflect the costs associated with providing a service, year-to-year variation, and whether packaged items are appropriately reflected in payment weights. CMS believes this new methodology will allow earlier detection of changes in the cost of services and may promote better stability in the payment system. In addition, it believes this will improve its ability to identify resource distinctions between previously homogeneous services.

Changes to APC Classifications for CY 2013

In the final rule, CMS identifies services with a modified APC assignment for 2013 with a status indicator of "CH." For 2013, CMS reassigned a number of ENT services to different APCs, resulting in fluctuations in payment for these services. For example, the sinus endoscopy with balloon dilation procedures (CPT 31295, 31296, and 31297) will remain in APC 0075, but will see a decrease in reimbursement for 2013 due to CMS' decision to add several lower cost procedures to the APC. For changes in reimbursement rates for otolaryngology related APCs see the Academy's full summary of the final rule. For a complete list of APCs and associated payment rates, access Addendum B to the final rule.

CMS also made several changes to their list of exemptions from the two times rule outlined above. CMS makes exceptions in unusual cases, such as low-volume items and services. Two APCs included on the exception list for 2013 are relevant for the otolaryngology community: APC 0254 Level V ENT procedures and APC 0006 Level I Incision & Drainage.

Lastly, CMS finalized its proposal to create a separate cost center for implantable devices. While this policy change appears to cause the payment rates for many procedures to decrease, physicians and hospitals should be aware that they will now be able to bill for two APCs (the procedure APC and the device APC), where applicable, and that overall payment may not be reduced.

APC Assignments for New 2013 CPT Codes

After the proposed rule was issued, the AMA CPT Editorial Panel created new CPT codes that became effective January 1, 2013. New CPT codes relevant to otolaryngology-head and neck surgeons include two new pediatric polysomnography codes (CPT 95782 and 95783) and several new allergy codes, including two ingestion challenge codes (95076 and 95079) and two percutaneous and intracutaneous allergy testing codes (95017 and 95018).

CMS believes this new methodology will allow earlier detection of changes in the cost of services and may promote better stability in the payment system. In addition, it believes this will improve its ability to identify resource distinctions between previously homogeneous services.

OPPS Payment for Hospital Outpatient Visits

Hospital Observation Status Policy

In its comments to CMS on the proposed rule, the Academy recommended that CMS cap the amount of time a beneficiary can receive observation services as an outpatient to provide clarity

on these requirements. The Academy also urged CMS to increase transparency of patient status for both patients and physicians and recommended that CMS automatically classify anyone who had received care in the facility setting for more than 48 hours as an inpatient. In response, CMS did not implement any immediate changes regarding these policies, but stated it will take all public comments into consideration as it considers future action.

Hospital Outpatient Visit Policies

For 2013, CMS will continue to recognize the three types of CPT and HCPCS codes describing clinic visits, Type A and Type B emergency department visits, and critical care services. A complete list of these codes can be found in Table 38 of the final rule. CMS will also continue to recognize existing CPT codes for critical care services; to set payment rate based on historical data; and to package the costs of care and ancillary services, despite AMA CPT Editorial Panel policy that requires hospitals to report ancillary services and associated charges separately. As a result, they will continue to use claims processing edits that package payment for ancillary services provided on the same date of service as critical care services. CMS states it will continue to monitor this policy for potential revisions in the future.

Clarification of Supervision Requirements for Therapy Services in Hospitals and CAHs

In response to concerns expressed in past years' MPFS public comments, CMS clarifies that it does not intend to establish different supervision requirements for hospitals and critical access hospitals (CAHs) under §410.27 of the regulations for physical therapy, speech language pathology, and occupational therapy services provided in the outpatient setting when furnished under a certified therapy plan of care. CMS notes that if the services are billed by the hospital or CAH as therapy services, the supervision requirements do not apply. However, CMS notes that policies covered by §410.27,of the Medicare coverage manual, regarding supervision and other requirements do apply to PT, SLP, and OT services when those services are not furnished under a certified therapy plan of care (referred to as "sometimes therapy" services). Of note, the list of "sometimes therapy" codes includes negative wound pressure therapy codes and several debridement codes that may be used by otolaryngology-head and neck surgeons.

Hospital Outpatient Quality Reporting (OQR) Program

As established in previous rules, hospitals will continue to face a two percent reduction to their OPD fee schedule update for failure to report on quality measures in the OQR Program. Program measures can be accessed at www.QualityNet.org. CMS has confirmed it will continue the Electronic Reporting Pilot in 2013. Under this program, eligible hospitals and CAHs can continue to report clinical quality measure results by attestation under the Medicare EHR Incentive Program. CMS will also continue efforts toward alignment of several quality-reporting programs in an effort to relieve administrative burden.

ASC 2013 Final Payment Rates

In its final rule, CMS used the updated Consumer Price Index for All Urban Consumers (CPI-U) of 1.4 percent minus an updated MFP adjustment of 0.8 percent, and as a result will implement a 0.6 percent increase to the ASC conversion factor. These changes result in a CY 2013 conversion factor for ASCs of $42.917 compared to the 2012 CF of $42.627.

Surgical Procedures Designated as Office Based

Annually, CMS proposes to update payments for office-based procedures and device-intensive procedures using its previously established methodology. Office-based procedures are defined as surgical procedures that are used more than 50 percent of the time in the physicians' offices. **In the 2013 final rule, CMS has finalized, based on review of CY 2011 utilization data, permanent designation of six covered surgical procedures as "office based" within the ASC setting.** Notably, three of those codes are Nasal/Sinus endoscopy procedures (CPT codes 31295, 31296, and 31297). This confirms that CMS will pay for these procedures at the lesser of the 2013 MPFS non-facility Practice Expense (PE) relative value unit (RVU) amount, or the proposed 2013 ASC payment amount.

Payment for Device-Intensive Procedures in the ASC Setting

CMS finalized adoption of the OPPS policy related to full benefit/full cost devices. This applies when the ASC receives the device without cost or with full (FB) or partial (FC) credit from the manufacturer. CMS also updated the ASC list of covered surgical procedures that are eligible for payment according to device-intensive procedure payment methodology, consistent with the proposed OPPS device dependent APC rules. CPT 69930, implantation of cochlear devices, is one of the services for which this policy will apply in CY 2013. The Agency has also published a list of specific devices for which the FB or FC modifier must be reported when the device is furnished at no cost (FB) or with full or partial credit (FC) that includes: **L8614 (*cochlear device/system*); L8680, 85, 86, 87, 88 (*Implant neurostimulators—five codes*); and L8690 (*Auditory osseo dev, int/ext comp*).**

ASC Quality Reporting Program

CMS finalized October 2012 as the date when ASCs were required to begin reporting claims-based measures that will be used to calculate 2014 payment. **Payment penalties for ASCs who do not adequately report will remain at 2 percent.** Quality measures can be found at: www.Qualitynet.org.

For more information on the final rule, access the Academy's full summary of finalized requirements at http://www.entnet.org/Practice/Summaries-of-Regulations-and-Comment-Letters.cfm#CL or email questions to Academy health policy staff at HealthPolicy@entnet.org.

2013 OIG Work Plan: Reviews That May Affect Otolaryngology

In October 2012, the Office of Inspector General (OIG) issued its Annual Work Plan for the next fiscal year, which stipulates the areas of the Medicare and Medicaid programs that the OIG (Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, and Office of Counsel to the Inspector General) will monitor and investigate to promote efficiency and eliminate incorrect billing, waste, fraud, and abuse in these programs. The OIG releases the details of its findings in reports that outline its methodology for determining payment or billing errors and recommendations to the Centers for Medicare & Medicaid Services (CMS) to recoup erroneous payments. In addition, the Medicare Recovery Audit Contractors (RAC) will monitor the improper payment trends that the OIG indentifies in these reports to guide its selection of new areas to audit in Medicare Part A and Part B programs.

The OIG plans to focus on Medicare Part A and Part B claims billed in various settings, including hospitals, acute care hospitals, hospital outpatient setting, physician offices, and ambulatory surgical centers. Notably, in addition to continuing its oversight of the Recovery Act and the Affordable Care Act (ACA), the OIG will also review CMS' documentation of its contracts with Medicare Administrative Contractors (MACs) and CMS' ongoing monitoring and assessment of MAC performance.

We have reviewed the 2013 work plan and believe the following new and ongoing OIG initiatives could affect otolaryngologist–head and neck surgeons. Members should also remember that several initiatives instituted in previous years are still ongoing.

Some of the new areas that OIG will review in 2013 include:

- OIG will analyze claims data to determine how much CMS potentially could save if it bundled outpatient services delivered up to 14 days prior to an inpatient hospital admission into the diagnosis related group (DRG) payment. Currently, Medicare bundles all outpatient services delivered three days prior to an inpatient hospital admission.
- OIG will review Medicare payments made to hospitals for beneficiary discharges that should be coded as transfers and determine whether these claims were appropriately processed and paid.
- Providers may use GA or GZ modifiers on claims they expect Medicare to deny as not reasonable and necessary. After a recent OIG review showed that CMS paid for 72 percent of pressure-reducing support surface claims with GA or GZ modifiers resulting in $4 million in inappropriate payments, OIG will determine the extent to which Medicare improperly paid claims from 2002 to 2011 in which providers entered GA, GX, GY, or GZ service code modifiers.
- Since OIG suspects that hospitals may be acquiring Ambulatory Surgical Centers (ASCs) and providing outpatient surgical services in that setting, for 2013 OIG will be reviewing the extent to which hospitals acquire ASCs and convert them to hospital outpatient departments. OIG plans on also determining the effect of such acquisitions on Medicare payments and beneficiary cost sharing.
- After recent Government Accountability Office (GAO) reports have revealed pervasive deficiencies in CMS' internal control and contract management, OIG will review the number, types, and dollar amount of active CMS contracts and examine how CMS maintains all of its contract information. In addition, OIG will assess CMS' monitoring and performance of MACs and assess MACs implementation of Part A and Part B system edits.
- OIG will determine the extent to which Medicare's supply replacement schedules for supplies related to continuous positive airway pressure (CPAP) machines vary from those of Medicaid, Department of Veterans Affairs (VA), and Federal Employees Health Benefits programs.
- After recent drug shortages, OIG will attempt to determine the extent to which providers of select Part B-covered drugs in short supply report difficulty acquiring those drugs. OIG will ask providers to describe their behavior when facing a drug shortage and any effect on pricing, quality of care, and market availability.

In addition to its new initiatives, the OIG will continue previously launched initiatives by continuing to review:

- Hospitals' controls for ensuring the accuracy and validity of data related to quality of care that they submit to CMS for Medicare reimbursement. Hospitals must report quality measures in order to avoid penalties to their Medicare payments.
- Medicare: Hospital claims with high or excessive payments.
- Medicare payments for Part B Imaging Services.
- Medicare Part B paid claims and medical records for interpretations and reports of diagnostic radiology services (X-rays, CT, and MRIs) performed in emergency hospital settings.

- Off-label use of Medicare Part B prescription drugs and medical necessity of reimbursement.
- Medicare payments for observation services provided during outpatient visits.

> "Since the work plan primarily focuses on providers' compliance with Medicare requirements, it is vital that members adhere to documentation requirements, particularly given the transition to electronic health records and requirements for meaningful use."

- Medicare claims for same day hospital readmissions.
- Medicare Part B claims and appropriate report of place-of-service codes.
- The appropriateness of the process for devising ambulatory surgical center (ASC) reimbursement rates under the revised ASC payment system.
- Safety and quality levels of surgeries performed in an ASC setting.
- Place of service coding errors for services performed in an ASC and hospital outpatient departments.
- E/M services reimbursed as part of the global surgery fee in effort to determine if practices have changed since institution of the concept in 1992.
- Electronic Health Record E/M Claims with identical documentation across services.
- Medicare/Medicaid Incentive Payments for provider adoption of Electronic Medical Records.
- Appropriateness of Medicare payments for sleep studies and sleep test procedures.
- Medical necessity of high-cost diagnostic tests billed to Medicare.
- Medicare Outpatient Hospital Claims for the Replacement of Medical Devices: OIG will determine whether hospitals submitted outpatient claims that included procedures for the insertion of replacement medical devices in compliance with Medicare regulations.
- The extent to which providers comply with assignment rules (for participating and non-participating providers).
- Physician billing for incident-to services so OIG can see if the error rate is higher than non-incident-to services.
- Physician billing of unusually high cumulative part B payments made to an individual physician or supplier, or on behalf of an individual beneficiary, during a specified period.
- Medicare Part A and B claims submitted by top error-prone providers.

Since the work plan primarily focuses on providers' compliance with Medicare requirements, it is vital that members adhere to documentation requirements, particularly given the transition to electronic health records and requirements for meaningful use. As such, we encourage members to access Academy resources and tools designed to assist with compliance prior to submitting your claims:

- The Academy's Coding Hotline: 1-800-584-7773.
- Correct Coding Initiative Edits assists with modifier usage: https://www.cms.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage.
- Ensure you are aware of maximum units you can report for a service on the same patient on the same date of service (Medically Unlikely Edits (MUEs) https://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage.
- Be mindful of global periods for procedures when submitting claims.
- Access the Academy's website for updated coding resources (http://www.entnet.org/practice/Guidelines.cfm) prior to submitting your claims. Please email Healthpolicy@entnet.org for further details.

Reference

1. 2013 OIG Work Plan: https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf; Accessed December 2012.

AAO-HNS Coding Resources

Experts agree that correct coding may be the single most important area for surgical practice improvement. However, keeping up with the constant changes in claims coding and billing rules can be costly and time consuming. Therefore, the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS)—as a part of its ongoing endeavor to support members—has several resources available for members, as highlighted below.

AAO-HNS CPT for ENT Articles

These articles provide specific, coding guidance from the AAO-HNS Physician Payment Policy (3P) workgroup and AAO-HNS CPT team, on common coding inquiries received from Members, or key coding changes impacting Otolaryngology-Head and Neck Surgery. They can be found online at: http://www.entnet.org/Practice/cptENT.cfm.

New for 2013: Academy Coding Corner

Beginning for 2013, the Academy will include critical updates and coding changes to Members via multiple mechanisms, including the *Bulletin* and the HP update. Stay tuned for more information.

AAO-HNS 2013 Coding Workshops

The Academy, in partnership with Karen Zupko & Associates, provides members with the opportunity to enhance the business side of their clinical practice. Held eight times a year, these two day workshops enhance the business side of clinical practice and assist with the most current coding challenges. Visit www.entnet.org/coding for more information.

AAO-HNS Coding Assistance

As an Academy member, you receive several complimentary coding guidance consultations to help with your more complex coding questions. To access a coding specialist, call 1-800-584-7773, 9 am-6pm ET. If you would like to provide feedback on guidance provided by the coding specialist, please contact the Health Policy department at HealthPolicy@entnet.org.

Additional Coding Resources

We urge physicians to reserve the use the AAO-HNS Coding Hotline for complicated coding questions. For more general education and guidance, we strongly recommend that you and/or your office billing claims staff annually attend the AAO-HNS Coding workshops as well as some or all of the following coding educational workshops and/or visit the websites noted for coding reference materials:

- **Medicare Learning Network** offers 17 web-based programs. Details are on the CMS website: http://www.cms.hhs.gov/MLNProducts (click on the link to web-based training modules at the bottom of the page).
- **American Medical Association** offers many resources including: CPT/RVU search; 2013 Code Changes book and workshop, CPT Assistant, webinars, CPT/RBRVS Annual Symposium, articles, etc. See: http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/cpt-products-services.page?

Coding & Reimbursement Workshops for Otolaryngology

Enhance the business side of your clinical practice by attending the regional workshops conducted by Karen Zupko & Associates. The course sessions, held Friday and Saturday, are designed to help you to run a better business and ensure that you are coding correctly:

Profitable Practice Management
- Mastering ENT Coding

The second day of each workshop is approved for *AMA PRA Category 1 Credit™* for physicians.

Workshop location and dates for 2013:

Dallas, TX	Hotel ZaZa	February 1-2
Orlando, FL	Wyndham Grand Orlando Resort, Bonnet Creek	February 15-16
Las Vegas, NV	Encore at Wynn Las Vegas	March 8-9
Chicago, IL	The Drake Hotel	April 12-13
Nashville, TN	Loews Vanderbilt Hotel	August 23-24
Minneapolis, MN	Radisson Blu Mall of America	September 13-14
Las Vegas, NV	The Westin Las Vegas	October 25-26
Chicago, IL	Hyatt Chicago Magnificent Mile	November 8-9

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For more information, visit www.entnet.org

Communication Is Key

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

It has been more than a decade since the Institute of Medicine's sentinel report on errors in healthcare, which outlined ways to systematically improve the quality of care in our country. There have been tremendous technological improvements during the past decade. For example, there is now broad reporting and acceptance of macro-level data, which allows trends to become apparent that can affect outcomes for our patients. Certainly, technology can be credited for helping to move the patient safety and quality improvement agenda forward in a dramatic fashion during the past decade.

However, there is one issue that persists and at times eludes the healthcare profession: enhancing communication. We function in an antiquated communication paradigm where we see a patient in the office, dictate a letter, and then mail the letter to our referring physician. Usually by the time the physician receives our letter, we have operated on the patient and they are seeing us for post-operative visits. I am sure you can think of many similar examples. Other industries have similar communication issues, but have been able to embrace technology and use it to greatly enhance communication and service (think of Wall Street two decades ago versus now vis-à-vis trading equities).

Of course, the electronic medical record is a giant leap forward in documentation and record keeping internally for practices and healthcare systems. However, at my last count there were hundreds of electronic medical record (EMR) companies out there—even one with free EMR. The problem with EMRs, however, is with inter-practice communication and within in a healthcare system. There is no doubt that we can and should track patient records; however, the EMRs do not address the communication void.

It has been noted that more than a quarter of adverse events and medical errors involve communication breakdowns. This is not too hard to fathom because for a medical error to occur there are usually multiple breakdowns in the system that allow an issue to persist and manifest as an error.

I often wonder with enhanced, rapid, or real-time communication if medical errors would be markedly reduced.

The data seem to indicate so. There are certainly emerging platforms that exist to help change the manner in which we communicate in healthcare. I would posit that at present we can adopt low-technology solutions while awaiting broad acceptance of technologically more sophisticated alternative communication modalities.

Simply, we can all attempt to over-communicate. I cannot fathom an instance where over-communication would be detrimental to patient care. Indeed, the military and other industries use refined communication tools, such as the **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation (S-B-A-R) technique to ensure proper communication. How about the drive through at fast food establishments? They often invoke the read back and verify rule with your order. They want to ensure your order is correct. Perhaps in healthcare we can do similarly to ensure the medication we dispense or order we give is correct.

One of the constraints we have faced is the burden of regulations. HIPAA does place limits on how we can communicate, especially with electronic protected health information (e-PHI), which has come under tremendous scrutiny. Certainly there are technologies that are being developed for substantial cost, and some for free, that will improve healthcare communication. I implore Academy members to contemplate low-technology solutions for communication and seek platforms that are designed to enhance technology communication. The end goal being a reduction of adverse events and medical errors by improving the manner in which we communicate healthcare information.

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.

Foundation's Live Events Offer Education and Networking Opportunities

AcademyU®, the Foundation's otolaryngology education source, offers five types of learning formats that include knowledge resources, subscriptions, live events, eBooks, and online education. Each one contains elements that make up the breadth of the education opportunities available through the Academy.

In this article we will explore the two live events offered by the Foundation: the Annual Meeting & OTO EXPO℠ and the Coding and Reimbursement Workshops. Both of these provide opportunities for interaction with experts and networking with colleagues from around the world. Both also provide continuing education credit for participants.

Annual Meeting & OTO EXPO℠

As you know, the Annual Meeting & OTO EXPO℠ is the world's best gathering of otolaryngologists, together with the world's largest collection of products and services for the specialty. Tailored specifically for practicing otolaryngologist–head and neck surgeons and associates, researchers in otolaryngology, senior academic professors and department chairs, leaders of international societies, fellows-in-training, and residents. The 2013 Annual Meeting & OTO EXPO℠ will take place September 29–October 2 in Vancouver, BC, Canada.

The education component of each annual meeting is composed of instruction courses, miniseminars, guest lectures, scientific oral presentations, and posters. Instruction courses address current diagnostic, therapeutic, and practice management topics. Miniseminars are presentations, case studies, and interactive discussions that provide an in-depth, state-of-the-art look at new research in a clinical area. Oral presentations present findings on scientific research, surgical procedures, practices, and approaches to practicing physicians, residents, and medical students. Posters contain innovative information on original scientific research conducted by young investigators.

While numerous education options are available, the OTO EXPO℠ itself is a focal point of networking and career enriching opportunities. Here the attendees are able to visit with representatives from more than 300 companies that cater to every aspect of otolaryngology practice, including device manufacturers, pharmaceutical companies, and practice management service providers.

Participants at the 2012 Annual Meeting & OTO EXPO praised both the excellent education content and the expansive exhibit hall.

- "Excellent conference with outstanding panels and speakers."
- "Excellent. I was amazed at the new technology presented by exhibitors."
- "Very insightful presentations all around; great display of newer technologies and surgical techniques."

Coding and Reimbursement Workshops

The Coding and Reimbursement Workshops are regional two-day events that enhance the business side of clinical practice and assist with the most current coding challenges. Day One of these workshops is designed to provide an overview of practice and reimbursement management and appropriate metrics and measurements for ENT practices. Day Two addresses coding office procedures, ancillary service coding, and surgical coding procedures.

The workshops are offered in conjunction with Karen Zupko and Associates (KZA) and take place eight times a year in select cities. The Academy's Health Policy staff works with KZA to design new content for each year's workshops. The Core Otolaryngology and Practice Management Education Committee (COPMEC), under **Brendan C. Stack, MD,** ensures its overall quality and success.

This year's workshop themes are "Take Your Practice to the Next Level" and "Mastering ENT Coding." Taken together, these two programs will show participants how to optimize their entire revenue cycle, and demonstrate how using the right processes speed payments and reimbursements.

"We know you have many options when it comes to coding courses. But we guarantee you'll find that these workshops are an exceptional educational experience that is head and shoulders above the rest," said Karen Zupko.

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We extend a special thank you to the partners of the AAO-HNSF Industry Round Table (IRT) program. Corporate support is critical to realizing the mission of the Academy, to help our members achieve excellence and provide the best ear, nose, and throat care through professional and public education and research. Our partnerships with these organizations who share this mission allow the Academy to continue to provide the programs and initiatives that are integral to our members providing the best patient care.

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Working with Autistic Children in Kazakhstan

James D. Smith, MD

Since separating from the Soviet Union in the early 1990s, Kazakhstan, a country with a population of about 15 million, has moved from an agrarian society to an economic one fueled by oil discoveries and other natural resources. As in most mid-level world economies, the wealth is not evenly distributed.

In October 2012, I was privileged to join a team giving a conference in Almaty, Kazakhstan, on pediatric neurodevelopment disabilities, specifically autism, cerebral palsy, and developmental delay. Almaty, Kazakhstan's former capital, has beautiful scenery surrounded by 12,000-15,000-foot snow-capped mountains.

The team consisted of a developmental pediatrician; a pediatric neurologist from Astana, Kazakhstan's current capital, who helped with translation; a speech therapist specializing in working with autistic children; an occupational therapist; a teacher of special needs children; an intern who has her PhD in neurobiology; and myself.

Two years ago, we started doing this type of conference at a pediatric hospital in Nairobi, Kenya. It turns out that in many countries children with these disabilities are kept hidden at home, basically receiving few or no services for diagnosis, treatment, or education. In Kenya, on our second visit we were told that the average age of referral for children with disabilities had gone from eight years of age to three. This is a significant change with improved hope for treating these children.

After a short visit to Almaty in 2011, Tracy Buckendorf, CCC-SLP, speech pathologist, was invited to return with this team for a week's conference on pediatric neurodevelopmental disabilities. The initiation and organization came from a parent with a child with autism.

Although attempts were made to make the conference known in the medical community, there were only three or four physicians present. Of the nearly 90 attendees, about one-third were parents, one-third special needs teachers, and the rest were speech therapists, physical therapists, psychologists, and psychiatrists.

It turns out that the diagnosis and treatment of autism was the biggest draw. We found out that, by law, psychiatrists can only diagnose, but not treat, autism in many former Soviet Union countries. To further complicate early diagnosis and treatment, psychiatrists do not see children younger than four years of age. This means that the early critical period for training these children is missed.

Mountains on the outskirts of Almaty, Kazakhstan.

A parent asking questions to the panel about autism.

In Kazakhstan, we learned that there were fewer than 200 children diagnosed with autism. To further complicate their care, the autism diagnosis is changed to schizophrenia at age 16. Parents become frustrated as they recognize something is wrong, but the pediatricians tell them nothing is wrong. From the Internet they are suspicious that their child has autism, but they have nowhere to turn for help.

The feedback from the audience was overwhelmingly positive. Attendees from a neighboring country asked for a team to do the same training next year. Invitations also came from Tajikistan and Azerbaijan when they heard about the conference.

What did I learn from this trip? The satisfaction of working with a team of other specialties and other professionals to help educate parents, teachers, and other professionals in an area they were eager to learn more and they saw as a need.

I realized first, how fortunate we are to have services for children with disabilities, which in many countries are hidden from society; second, how short-term teams, which provide education and training, can make as much difference in lives as direct patient care. Finally, I realized that sharing with others can be a life-changing activity.

Operation Sight, Sound, and Smile Mission to Nepal

Eric D. Wirtz, MD
David Healy, MD
Scott Roofe, MD
Department of Otolaryngology
Tripler Army Medical Center, Hawaii

Operation Sight, Sound, and Smile, a program comprised of otolaryngology and ophthalmology, was developed at Tripler Army Medical Center in 2004. It was created with the goal of partnering with surgeons throughout Asia in caring for their local, underserved population. Our goal is to not only provide direct patient care, but also to collaborate with the local surgeons to build capacity and advance their capabilities to create a sustainable impact. Since its origin, Sight, Sound, and Smile has partnered with fellow surgeons throughout Asia in countries as diverse as Bangladesh, Sri Lanka, and Malaysia.

Birendra Army Hospital in Kathmandu, a city of nearly 1 million people in the center of Nepal, was the site of our most recent mission from September 18-26, 2011. Three otolaryngologists, **Scott B. Roofe, MD, David Y. Healy Jr., MD,** and **Eric D. Wirtz, MD,** two anesthesia providers, two surgical technicians, and a circulator participated.

Operation Sight, Sound, and Smile team (front l. to r.) Scott Roofe, MD, Nepalese medical resident, member of Nepalese Army, Michael Turner, and Mitchell Stone. (back l. to r.) Scott Croll, MD, Eric Wirtz, MD, and Dave Healy, MD.

Eric D. Wirtz, MD, visiting with a child and his father following his tympanomastoidectomy for cholesteatoma.

During our four surgical days, we performed more than 30 operative cases. The majority of these were tympanoplasties for near total perforations. In addition, we performed several tympanomastoidectomies for cholesteatoma and functional endoscopic sinus surgery for chronic rhinosinusitis with polyposis.

The Nepal trip proved to not only be a beneficial experience due to the patients who received surgical treatment for their chronic disease, but also due to the partnering that occurred between the Nepalese surgeons and our team. This partnership will continue to be fostered as there are plans to bring the Nepalese surgeons to Tripler Army Medical Center for continued collaboration. Tentative plans are set to return to Nepal in 2013 to further strengthen the partnership that has been created.

Global Outreach Project in Harare, Zimbabwe

Levi G. Ledgerwood, MD

A recent focus in global health is to address the portion of global burden of disease with a surgical cure. Cleft lip and palate, and congenital deformities represent a large portion of this burden, and require a level of expertise not routinely found in many locations worldwide. Nowhere is this more true than in Zimbabwe.

Operation of Hope is a non-profit organization that for 20 years has provided life-changing surgeries to people with cleft lip and palate deformities. **Travis T. Tollefson, MD, MPH,** and I recently had an opportunity to travel to Harare, Zimbabwe, as part of a seven-year-old project to foster a multidisciplinary team to provide support and education on surgical repair of these congenital deformities.

> "In collaboration with host country maxillofacial surgeons and residents, we have developed relationships for the ongoing care of these children. Such continuity is paramount to the success of any ongoing project, since so much of the care of these children takes place after the two-week project."

Drs. Tollefson and Ledgerwood examining a post-op patient at Harare Central Hospital, Harare, Zimbabwe.

Our trip to Harare included 10 days of surgery at the Harare Central Hospital, a tertiary care center that serves the poorer portion of the population of Harare and smaller neighboring cities. More than 200 children with various congenital malformations, many of whom had traveled several days to attend our screening clinic, greeted us. During our stay, the team performed more than 50 primary cleft lip and palate repairs, along with many other minor surgical procedures. The look on parents' faces when they saw their child for the first time after a cleft lip repair highlighted the profound personal affect of these surgeries for the patients and their families. However, the team is striving to improve upon the traditional vertical surgical mission paradigm. The collaborative team includes nurses, anesthesiologists, and others who contribute with lectures, supplies, and funding. The project also includes ongoing collection of surgical outcomes and determining a geospatial distribution of the congenital facial deformities in Zimbabwe.

This mission also enabled us to work with and train several local surgeons in cleft lip and palate repair. In collaboration with host country maxillofacial surgeons and residents, we have developed relationships for the ongoing care of these children. Such continuity is paramount to the success of any ongoing project, since so much of the care of these children takes place after the two-week project.

Overall, this experience was a powerful reminder of the stark contrast between medical care in the United States and developing nations. Operation of Hope has developed connections with the local government and community to obtain equipment and supplies for the mission, and continues to contribute to the medical community in Harare despite the political turmoil in the country. This important project in Harare has left an obvious mark on the community—one that can be seen in the smiles of all the children we have had the honor help there.

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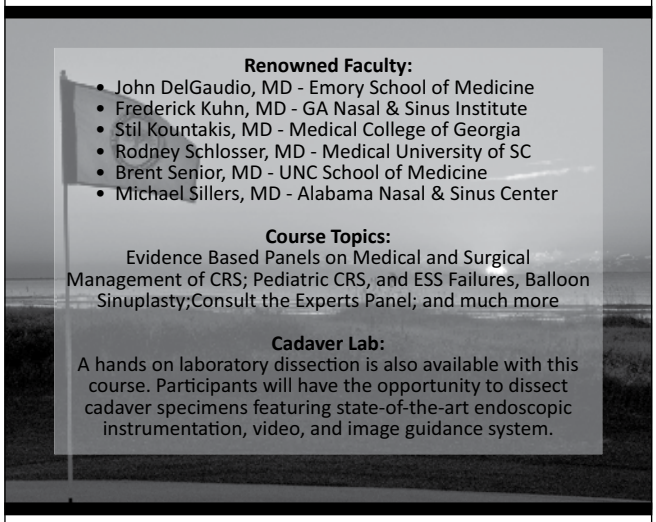

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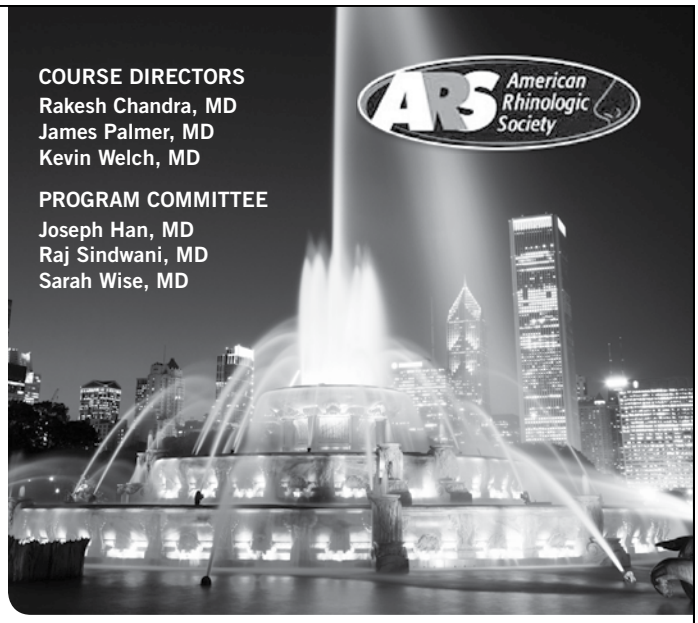

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http://www.hsc.wvu.edu/som/otolaryngology/

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LSUHSC – Dept of Otolaryngology – Head and Neck Surgery
Assistant Professor or Associate Professor
(full-time clinical, non-tenure track)

The Department of Otolaryngology-Head and Neck Surgery of LSU Health Sciences Center (New Orleans) is seeking a fellowship trained, BC/BE Laryngologist for a full-time faculty position at the rank of Assistant or Associate Professor (non-tenure track).

The selected candidate will practice primarily at the Our Lady of the Lake Medical Center Voice Center in Baton Rouge; this facility is a well established treatment resource for patients with voice, swallowing, and airway disorders serving Louisiana and the Gulf Coast. There is a collaborative clinical team established for patient evaluation and management, including laryngology, speech pathology and basic science support. The clinical practice encompasses all areas of laryngology with excellent departmental subspecialty coverage in neurotology, rhinology, head and neck oncology, facial plastic and reconstructive surgery and pediatric otolaryngology. Responsibilities include patient care, resident and medical student education, and the pursuit of clinical research. The candidate will assume a dedicated laryngology position in a busy clinical practice in a state of the art facility. Extensive collaborative research opportunities are available.

Salary and rank will be commensurate with the knowledge, education and experience of the individual. Candidates interested in working within a dynamic and stimulating setting combined with a generous package of related benefits are encouraged to provide a cover letter with clinical and research interests and current Curriculum Vitae to: ctorre@lsuhsc.edu; reference PCN12-205. LSUHSC is an AA/EEO employer.

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.

The successful candidate will have fellowship training with expertise in their specialty and is BC/BE. The candidate will join as an Assistant or Associate Professor and will be involved with resident and medical student education while developing a strong clinical practice and research interests.

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.

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**.

KU UNIVERSITY of KANSAS
Department of
Otolaryngology
Head & Neck Surgery

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.

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
713-383-3727 (fax)
Soham.Roy@uth.tmc.edu
http://www.ut-ent.org

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SCHOOL OF MEDICINE

Faculty Positions

THE DEPARTMENT OF OTOLARYNGOLOGY - HEAD & NECK SURGERY
is currently seeking to hire

ACADEMIC OTOLARYNGOLOGISTS

With training and/or interest in either microlaryngology or pediatric surgery

The successful candidates must demonstrate experience and capability. Academic appointment and compensation commensurate with training and experience. Practice income available to augment negotiated salary.

Send letter of interest and CV to:

Robert H. Mathog, M.D.
Professor and Chair
Department of Otolaryngology
540 E. Canfield, 5E-UHC
Detroit, MI 48201
(313) 577-0804

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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
- Pursue research in your area of interest

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. Geisinger South Wilkes-Barre (GSWB) is GWV's ambulatory campus.

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

For more information or to apply for this position, please contact:

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

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Philadelphia PA

The Thomas Jefferson University Department of Otolaryngology-Head and Neck Surgery is a high-volume academic practice currently staffed by 14 full-time faculty representing the subspecialties of head and neck oncology, otology/neurotology, voice and swallowing, facial plastics and reconstruction, sinus and skull base and general otolaryngology. We are seeking a BC/BE otolaryngologist to join an expanding faculty at Thomas Jefferson University and its affiliated hospital sites. We offer a great Center City location blocks from historic district with easy access to suburbs of the Mainline as well as Southern NJ.

General Otolaryngology-Head and Neck Surgery
Highly competitive salary and benefits package. Salary and faculty rank commensurate with experience and qualifications.

Please e-mail CV and letter of intent to:
Joanne.Gauthier@Jefferson.edu
Or Contact
William M. Keane, MD
The Herbert Kean, MD Professor of Otolaryngology-Head and Neck Surgery & Chairman, Department of Otolaryngology-Head and Neck Surgery
Department of Otolaryngology-Head and Neck Surgery
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215-955-6784

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For additional information about the position, please contact:
Robert P. Zitsch III, M.D.
William E. Davis Professor and Chair
Department of Otolaryngology—Head and Neck Surgery
University of Missouri—School of Medicine
One Hospital Dr MA314 DC027.00
Columbia, MO 65212
zitschr@health.missouri.edu

To apply for this position, please visit the MU web site at hrs.missouri.edu/find-a-job/academic/

The University of Missouri is an Equal Opportunity/Affirmative Action Employer and complies with the guidelines of the Americans with Disabilities Act of 1990. To request ADA accommodations, please contact (573) 884-7282 (V/TTY). Diversity applicants are encouraged to apply.

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AHNS	American Head and Neck Society
ALA	American Laryngological Association
ANS	American Neurotology Society
AOS	American Otological Society
ARS	American Rhinologic Society
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**AAFPRS will be participating in COSM 2013.*

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For questions, contact Beth Faubel at (312) 202-5033 or visit www.cosm.md

Purchase E.N.T.
Otolaryngology - Head & Neck Surgery

Purchase ENT, a well-established regional ENT practice in Western Kentucky, is actively searching for physicians to join our practice. Paducah, Kentucky offers everything from Broadway shows at the Carson Center to festivals like the annual BBQ on the River. Located a short 20 minute drive from Kentucky and Barkley Lakes, and the Land Between the Lakes National Recreation Area, where great recreational opportunities are offered, and also just a short two to three hour drive to larger cities like Nashville, Memphis, St. Louis and Louisville, Paducah is a great community. There is something for everyone in the region.

Purchase ENT is well respected in the medical community and is a very progressive practice offering in-office Allergy, Audiology, CT Scan, and Ultrasound. Additionally, there is an investment opportunity in a successful ambulatory surgery center. Although we are seeking candidates to practice general ENT, a fellowship in Otology or Head and Neck would be welcomed. For the successful candidate, the opportunity is a one year partnership track. For additional information about this great opportunity, contact Jim Wring, Practice Administrator at jwring@purchaseent.com or 270-408-3208.

South Florida ENT 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

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15 CME credit course focusing on rhinology and allergy, skin cancer and reconstruction, otology, head and neck cancer and facial plastic surgery.

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Website
entinthedesert.surgery.arizona.edu

For information, contact:
Pamela Mathewson
(520) 626-6673
pmathewson@surgery.arizona.edu

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 Section 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
Section Chief, Ear, Nose, and Throat
rweatherly@cmh.edu
Phone: 866-CMH-IN-KC/866-264-4652
www.childrensmercy.org

Department of Otolaryngology and Communication Enhancement
Boston Children's Hospital
Translational Research MD-PhD
Otology-Neurotology Faculty Position

The Department of Otolaryngology and Communication Enhancement at the Boston Children's Hospital (BCH) seeks a board certified or board eligible pediatric otolaryngologist or neurotologist who desires to develop primarily a pediatric otology or neurotology practice with a translational research component. An M.D. Ph.D. educational background is required. This position includes an academic appointment as Instructor, Assistant Professor or Associate Professor at the Harvard Medical School (HMS) commensurate with the individual's experience and qualifications.

The Department of Otolaryngology and Communication Enhancement has a vibrant otology and neurotology practice, and is affiliated with the F.M. Kirby Neurobiology Center at BCH, offering potential research interactions across the spectrum of the HMS institutions.

Interested candidates should submit a current CV, a two or three page description of research interests, and three to five reference letters to:

Michael J. Cunningham, MD
Chief, Department of Otolaryngology
Boston Children's Hospital
300 Longwood Avenue, LO-367
Boston, MA 02115
Email: michael.cunningham@childrens.harvard.edu

Boston Children's Hospital and Harvard Medical School are Equal Opportunity/Affirmative Action Employers. Women and minorities are encouraged to apply.

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Presbyterian Medical Group is seeking two BC/BE otolaryngologists to join our outstanding, well-established group of ENT providers. Have a satisfying full-spectrum ENT practice with a large built-in referral base while at the same time enjoying a great quality of life in the beautiful Southwest. ER call 4 days/month. Practice call shared equally among group. Our medical group employs more than 600 primary care and specialty providers and is the fastest growing employed physician group in New Mexico.

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Albuquerque thrives as New Mexico's largest metropolitan center and has been listed as one of the best places to live in the United States by several major publications. A truly diverse and multicultural city, Albuquerque offers you and your family a wide variety of experiences, outdoor activities and entertainment. It is also home to the University of New Mexico, a world renowned institution.

Contact Michael Criddle, MD at mcriddle@phs.org or Kay Kernaghan, Physician Recruiter, kkernagh@phs.org or 505-823-8770 for more information or to forward CV. Please visit our website at www.phs.org

MAYO CLINIC

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Juan Fernandez-Miranda, MD
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Mayo Clinic and Arizona Faculty:
Stephen F. Bansberg, MD
Timothy W. Haegan, MD
Joseph M. Hoxworth, MD
Erin K. O'Brien, MD
John F. Pallanch, MD
Naresh P. Patel, MD
Ryan M. Rehl, MD

Endoscopic Sinus and Skull Base Surgery 2013 is our second state-of-the art course designed for otolaryngologists and endoscopic skull base surgeons. The curriculum will focus on inflammatory sinus disease on April 3-4, highlighting advanced, salvage and novel treatment strategies. Endoscopic skull base surgery will be the focus April 5-6. The curriculum is designed to introduce the novice surgeon to basic techniques, and provide advanced training for the more experienced surgeon. Hands-on dissection sessions will be conducted in our world-class laboratory with fresh frozen cadavers, powered instrumentation and image guidance.

Accommodations: Westin Kierland Resort • *www.kierlandresort.com* • (480) 924-1202 • Residence Inn Phoenix Desert View at Mayo Clinic • *www.marriott.com/phxmh* • (800) 331-3131

Meeting Location: Mayo Clinic's Phoenix and Scottsdale campuses

To Register, Contact MSCPD: *www.mayo.edu/cme/otorhinolaryngology* • email: *mca.cme@mayo.edu* • (480) 301-4580

Featuring: Hands-on dissection, live prosection and endoscopic 3D anatomy

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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 NIH-funded 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.

MEDICAL OTOLARYNGOLOGIST OPPORTUNITY

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

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
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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.

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April 19-20, 2013
June 21-22, 2013
October 25-26, 2013

This workshop is intended for otolaryngologists interested in the most recent development in temporal bone surgical techniques.

Registration Fee:	$425
Location:	Allegheny General Hospital Pittsburgh, Pennsylvania
Course Co-Directors:	Douglas A. Chen, MD, FACS Todd A. Hillman, MD

For additional information, please contact Allegheny General Hospital, Continuing Medical Education, by e-mail at **tcochran@wpahs.org**, by phone at (412) 359-4952 or by fax (412) 359-8218. To download a brochure or register online, please visit our Web site at **aghcme.org**.

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