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American Academy of Otolaryngology—Head and Neck Surgery February 2012—Vol.31 No.02

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1. Manes RP, Tong L, Batra PS.: "Prospective evaluation of aerosol delivery by a powered nasal nebulizer in the cadaver model" Int Forum Allergy Rhinol, 2011; 1:366–371
2. Yuri M. Gelfand, MD; Samer Fakhri, MD; Amber Luong, MD, PhD; Seth J. Isaacs, MD & Martin J. Citardi, MD: "A Comparative Study of the Distribution of Normal Saline Delivered by Large Particle Nebulizer vs. Large Volume/Low Pressure Squeeze Bottle" 56th Annual Meeting of the American Rhinologic Society, September 25, 2010, page 38

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American Academy of Otolaryngology—Head and Neck Surgery February 2012—Vol.31 No.02

Out with the Old, In with the New: The Revitalized ENT PAC

One of the lesser known, but critically important, facets of the Academy's advocacy programs is its political action committee, ENT PAC.

22

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

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

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bulletin

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May Is the New March for Advocacy, the BOG, and Our Boards

In 2012, the AAO-HNS is returning to a specialty-specific format for its Washington, DC-based legislative advocacy events. For the last four years, otolaryngology-head and neck surgery partnered with other surgical groups to host the Joint Surgical Advocacy Conference (JSAC). Due to varying legislative priorities and conflicting schedules, a combined surgical meeting will not be held this year. This provides us with the opportunity to return to our own specialty-specific advocacy on Capitol Hill. With the 2012 national elections right around the corner, this will be a particularly interesting year providing an ideal opportunity to advocate for the specialty and our patients.

To accommodate our members' demanding schedules, we are combining the "OTO Advocacy Summit" with the Board of Governors (BOG) and the AAO-HNS/F Boards of Directors (BOD) spring meetings. As members of the Academy, this is a unique time to get to know your Board members, BOG leaders, and advocacy staff in a more personal setting. The BOD will meet on Saturday, May 5, followed by the BOG Spring Meeting May 6-7, in Alexandria, VA. The OTO Advocacy Summit will kickoff on Monday afternoon, May 7, concluding with "Hill" visits on Tuesday morning, May 8.

The OTO Advocacy Summit will provide an in-depth opportunity for Academy members to learn about our specialty's legislative priorities and supporting ground work, as well as a chance to heighten their personal advocacy skills. During this year's OTO Advocacy Summit, participants will:

- Hear from Members of Congress about current Congressional efforts to advance AAO-HNS legislative priorities;
- Get "insider" knowledge about top races in the 2012 elections;
- Attend pre-scheduled meetings with their Members of Congress and/or Congressional staffers;
- Be trained on advocacy and Capitol Hill "do's and don'ts;"
- Receive timely legislative updates from AAO-HNS Government Affairs staff;
- Visit the Academy's strategically located office on Capitol Hill; and
- Discover additional ways to become more involved with AAO-HNS legislative grassroots programs.

> "I strongly urge our membership to take the time to get involved and attend both the 2012 BOG Spring Meeting and the OTO Advocacy Summit."

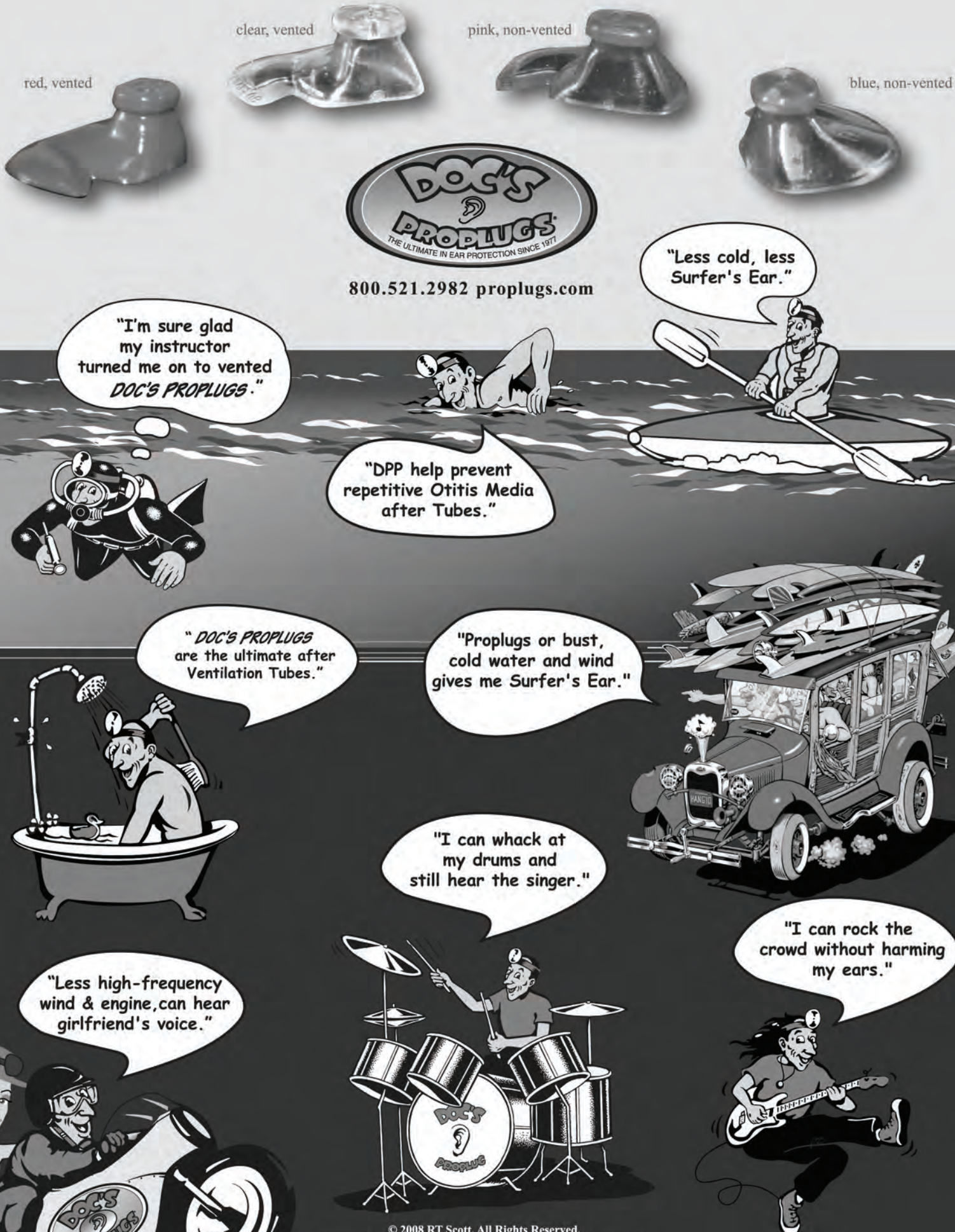
In addition, for those attendees who invest in the Academy's political action committee, ENT PAC, at a leadership club level, an exclusive PAC Investors event will be hosted at the historic George Washington Masonic Memorial in Alexandria, VA, just steps away from our Academy Headquarters. The ENT PAC reception is always a hit with attendees!

I strongly urge our membership to take the time to get involved and attend both the 2012 BOG Spring Meeting and the OTO Advocacy Summit. From my personal experience, spending time at the Academy and on Capitol Hill is very enlightening and invigorating. In all likelihood, during your legislative meetings, you will meet with the staffers of your U.S. Representatives and U.S. Senators, but don't be discouraged by this. These individuals have direct access to policymakers and your message will be carried forward. Although it might seem daunting for first-time attendees, the interactions are usually very cordial, and the Congressional staffers are genuinely interested in hearing your opinions. After all, you are a constituent, a.k.a. a voter!

Rodney P. Lusk, MD
AAO-HNS/F President

The Capitol Hill meetings also are a great opportunity to understand and respectfully discuss your elected officials' positions. It truly is fascinating to learn about all the "twists and turns" that occur behind the scenes during a legislative session.

The lessons learned and insight received during your brief visit to the Washington, DC area will prove to be helpful to you, your patients, your colleagues, and the specialty – such a wonderful "return on investment." And, who knows, you may catch "Potomac Fever" and schedule follow-up Capitol Hill meetings during your return visit this fall for the AAO-HNSF Annual Meeting & OTO EXPO in September!



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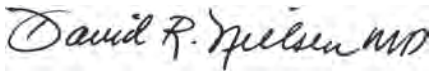

David R. Nielsen, MD
AAO-HNS/F EVP/CEO

For several years, you have read in this column of the increasing integration among Academy activities that used to be relatively isolated from one another. I'd like to share an excellent example of the crucial intersection of our education, health policy, and government affairs.

One of our most effective and popular themes for the month of February throughout the years has been our public outreach in pediatric otolaryngology. This has traditionally been done through our Kids ENT Health initiative. This year we celebrate the 10th anniversary of Kids ENT Health and our campaign to promote children's health interests. Past activities have addressed ear infections, sleep apnea, obesity, and foreign bodies in the airway and choking. Even though these are clinical concerns, each has a significant advocacy issue attached to it. In fact, when it comes to pediatrics, all clinical concerns should awaken our sense of advocacy. Children are a segment of our population who do not represent themselves in our political processes. It is incumbent upon us as adults, parents, physicians, and community leaders to champion the health and safety of our most precious resource: our children.

At the time of this writing, it has been brought to our attention at the Academy that there is a disturbing and growing incidence of infants and children ingesting small lithium batteries—the kind frequently found in toys. Unlike hearing aid batteries, of about the same size, these lithium batteries in toys are more corrosive and, when ingested, do more damage to the digestive tract or airway. Their invasive corrosiveness requires active and urgent removal, since any time taken to image, track, or wait for clinical signs to emerge can dramatically increase the amount of damage done.

A group of engaged and devoted leaders and pediatric otolaryngologists from the Academy, American Academy of Pediatrics (ASPO), The Society for Ear, Nose and Throat Advances in Children (SENTAC), American Academy of Pediatricians (AAP), American Broncho-Esophagological Association (ABEA), and health plans are discussing and working on what can be done to address this problem. I have asked that the Academy be included in the conversation. The topic is not new and many of you have been trying to call attention to the need to eliminate this danger for years. Proposed solutions have included public education in parenting magazines, online and social media, and general media. Other actions focused on negotiations with manufacturers and the industry to radiographically tag such batteries so they can easily be distinguished from other disc-like foreign bodies; re-engineering toys and manufacturing processes to reduce the risk of children finding and ingesting batteries; and even legislation and regulatory requirements to compel all manufacturers of batteries and toys that use them to engage in systematic methods of preventing ingestion.

> "This year we celebrate the 10th anniversary of Kids ENT Health and our campaign to promote children's health interests."

Engaging as a group, we also discuss how we can leverage our clinical information effectively for appropriate regulatory oversight through existing mechanisms. We have contacted the Food and Drug Administration (FDA) and the Consumer Product Safety Commission (CPSC) for their response. The FDA has oversight for hearing aid batteries, but hearing aids are not the main problem. The CPSC has oversight for the lithium batteries in toys, and as yet, we do not have a solution through them, but we hope to be able to work through them to address this. Included in the dialogue are companies that specialize in product safety, and serve as consultants to industry as well as to Congress on ways to reduce risk to consumers.

In the meantime, our Government Affairs staff has provided information and is following up on proposed legislation that would require the radiographic marking of lithium batteries. Both the House and the Senate have resolutions or bills proposing strict oversight and the development of mitigation strategies for toy battery ingestions. At the time of this writing, it is not clear how these will make their way through the legislative process, but we are monitoring and encouraging passage.

As you can see from this example, strong links between clinical concerns and advocacy on behalf of our vulnerable patients are a requirement for success. The tendency to see the Academy services functioning in silos is being replaced by a greater understanding of the need to integrate of all our programs. We take very seriously our ethical responsibility to advocate on behalf of the best interest of our patients, and we unite our efforts to continually focus on patient-centered care in both clinical and health policy matters. We urge you to join us in this integration and unity of purpose.

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We Must Show Up: 2012 OTO Advocacy Summit

Paul M. Imber, DO
Chair, Board of Governors Legislative Representatives Committee

The past two years have been replete with political turmoil and manipulation of the delivery of healthcare in America. This was most recently demonstrated by the bipartisan ineptitude and adolescent, counterproductive posturing that led to the 11th-hour reprieve of the 27.4 percent cut in physician payments until February 29, 2012. Of course, this will lead to another six weeks of bickering and whining among the factions of Democrats and Republicans on the Hill, culminating in another short-term band-aid. The need for a long-term fix of the SGR-based formula for calculating physician payment becomes more imperative each year. The legislative branch of our government must be informed, again and again, of the impact to patient care of the elderly and the chronically ill if the problem is not solved.

We must show up and be at the table to have our voices heard.

Dr. Nurse, Dr. Audiologist, Dr. Speech Pathologist—Dr. Doctor? Will the real doctor please stand up! The public is confused and misled by marketing ploys that are designed to misinform, leading to waste in healthcare expenditures and possible misdiagnosis and inappropriate treatment. Caveat emptor should not apply to healthcare. Our country needs uniform truth-in-advertizing laws that will ensure that the consumer understands what he or she is purchasing and from whom. Federal guidelines need to be established and enforced. Legislation (HR-451) has been propsed.

Paul M. Imber, DO

We must show up and be at the table to have our voices heard.

These are but a few of the issues that will be addressed at the **2012 OTO Advocacy Summit, May 7-8, 2012.** This meeting is coordinated with the Board of Directors and Board of Governors meetings to facilitate maximum attendance. Come enjoy the legislative training sessions, networking, and the ENT PAC Investor reception. The Summit will culminate with your visit to Capitol Hill and meetings with your Representative and Senatorial offices and you will be provided with professionally prepared briefs and handouts. This is your opportunity.

We must show up and be at the table to have our voices heard.

BOG Executive Committee Miniseminar Review and Preview

Peter Abramson, MD
Chair, Board of Governors Socioeconomic & Grassroots Committee

The 2011 BOG executive committee miniseminar at the Academy meeting in San Francisco, "Hot Topics in Otolaryngology: 2011," was well attended and very informative. The four panelists discussed various topics at the forefront of otolaryngology.

Larry Geller, MBA, a former hospital administrator and current medical consultant from Atlanta, GA, discussed hospital-physician integrated delivery models. Accountable care organizations and clinically integrated networks were a few of the topics reviewed in this rapidly changing landscape of our field.

Raymund C. King, MD, an otolaryngologist and attorney practicing law in Dallas, TX, reviewed how healthcare reform will affect the practicing physician. He delved into the intricacies of the new healthcare legislation, as well as Stark Laws and anti-kickback regulations. He stressed the influence of potential veiled consequences to the practicing physician.

Peter Abramson, MD

Michael J. Koriwchak, MD, an otolaryngologist, electronic health record consultant, and popular blogger on medical record-related issues, updated us on the payments thus far for completion of meaningful use parameters.

Rick G. Love, MD, a practicing otolaryngologist from Montgomery, AL, gave an update on payment for emergency department call responsibility. He reviewed the pay-for-call climate and updated us on recent OIG activity on this issue. Dr. Love spent a great deal of time investigating this subject and helped to formulate the Academy stance on this topical issue.

The panel presentations sparked a robust question-and-answer session.

The 2012 BOG miniseminar, organized and moderated by our current BOG Secretary, **Wendy B. Stern, MD**, will be a follow-up to the 2011 miniseminar. "Hot Topics: ENT and Election Year/What will 2012 Bring?" will feature nationally recognized speakers focusing on deficit reduction and its subsequent influence on healthcare, key federal healthcare regulations, and where we are with healthcare reform in this presidential election year. We hope to see you all there.

I would like to extend a special thanks to the Academy office staff, in particular Richard Carson and Bethany Clifton, for their hard work in helping to organize our yearly miniseminars.

Otolaryngology at the AMA 2011 Interim Meeting

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

The American Medical Association (AMA) conducted its 2011 Interim Meeting November 12-15, 2011, in New Orleans, LA. Your Academy was represented by **Liana Puscas, MD**, delegation chair, **Michael S. Goldrich, MD, Shannon P. Pryor, MD,** and **Robert M. Puchalski, MD**. In addition, **Alpen A. Patel, MD**, served as an alternate delegate to the meeting. Joy Trimmer, JD, senior director of AAO-HNS Government Affairs, and Jenna Kappel, MPH, MA, director of AAO-HNS Health Policy provided excellent staff support. This report aims to provide Academy membership with a better understanding of the responsibilities of the delegation members and staff at AMA meetings.

The responsibility of the delegation members is to represent the policies and views of the AAO-HNS on issues that pertain to otolaryngology-head and neck surgery, and medicine as a whole. Like the delegates, Academy staff members attend AMA meetings to dialogue with others from state and specialty medical societies on topics of interest, such as scope of practice, the sustainable growth rate (SGR) formula, and tort reform. In addition, our staff provides updates and information on legislative and regulatory issues.

Although our delegation is small, it has been active in AMA activities.

"The responsibility of the delegation members is to represent the policies and views of the AAO-HNS on issues that pertain to otolaryngology-head and neck surgery, and medicine as a whole."

At this meeting, Dr. Puscas chaired Reference Committee B dealing with legislative issues. The function of the Reference Committee is to hear testimony on resolutions submitted by AMA members and delegations from state and specialty societies. The Reference Committee then consolidates and evaluates the testimony and proposes action on the resolutions. The recommendations are placed before the House of Delegates, which then makes the ultimate decisions regarding AMA policy. Dr. Pryor began a two-year term at this meeting as a member of Reference Committee F, which deals with governance issues internal to the AMA. Dr. Puchalski, who serves on the AMPAC Board of Directors, was elected to chair AMPAC's Congressional Review Committee.

The AMA has an Otolaryngology Section Council, which comprises all otolaryngologists within the AMA House of Delegates. Members come from multiple state societies and otolaryngology specialty societies (AAO-HNS, Triologic, AAOA, and AAFPRS). The Section Council offers a valuable venue for colleagues to gather and discuss issues pertinent to otolaryngology, as well as receive and confer regarding national and state legislative updates. Dr. Goldrich is the current chair of the Section Council, and Dr. Puscas was re-elected vice-chair during this meeting.

"Members come from multiple state societies and otolaryngology specialty societies (AAO-HNS, Triologic, AAOA, and AAFPRS). The Section Council offers a valuable venue for colleagues to gather and discuss issues pertinent to otolaryngology, as well as receive and confer regarding national and state legislative updates."

The AMA also has several Sections under its larger canopy. Dr. Patel represented the Academy in the Young Physicians Section; **Jeffrey J. Houlton, MD**, served as our representative to the Resident and Fellows Section; and **Christie L. Morgan, MD**, represented the Academy as a resident delegate to the AMA House of Delegates.

Within the larger House of Delegates, there are multiple otolaryngologists who also served in various ways. **Bruce A. Scott, MD**, serves as secretary of the Otolaryngology Section Council, and **Edward Buckingham, MD**, served on Reference Committee B with Dr. Puscas. **Russell W. H. Kridel, MD**, and **Srinivas "Bobby" Mukkamala, MD**, both serve on the AMA's Council on Science and Public Health. **Dennis S. Agliano, MD**, serves on the Council on Ethical and Judicial Affairs (which Dr. Goldrich served on for eight years).

Rest assured—our specialty is well represented and has a notable presence at the AMA meetings. Though we may not always agree with the final policies developed at the House of Delegates meetings, we do have a voice.

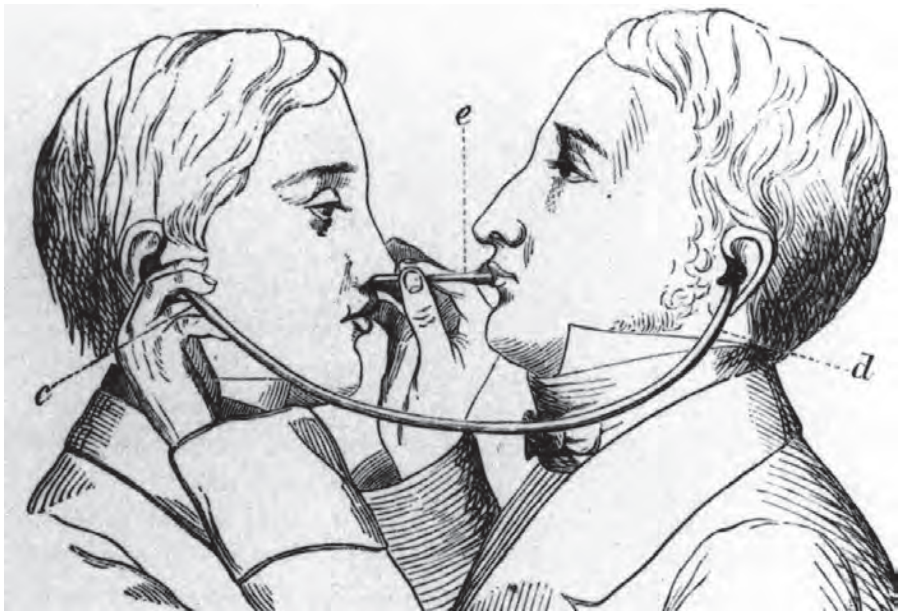
Evolution of Eustachian Tube Surgery: 300 Years and Counting

Edward D. McCoul, MD, MPH

Physicians have sought an effective treatment for dysfunction of the Eustachian tube (ET) for nearly three centuries. The earliest recorded attempts from the early 18th century involved transoral or transnasal catheterization, though which insufflation and irrigation with various substances could be applied. Forcible bougie dilation and endoluminal irradiation are described in several historical sources. The practice of catheterization continued through the 19th century, while very few surgeons attempted surgical reconstruction of the ET.

Until the late 20th century, the prevailing belief among surgeons and anatomists was that the ET is a passive conduit with a relatively static lumen. Most surgeons presumed that ET dysfunction was caused by a stenosis in the bony portion of the ET; techniques for drilling the temporal bone were described for both the transcanal and middle fossa approaches. Subsequent attempts to improve middle ear aeration sought to bypass the ET entirely. Tympanomaxillary shunting, tympanofrontal shunting, and transposition of Wharton's duct were all described with limited acceptance. Each of these techniques was aimed at relieving obstruction at the ET isthmus within the temporal bone.

The later 20th century brought a paradigm shift in which the ET was viewed not as a static structure but a dynamic one. The availability of fiberoptic endoscopy facilitated observation of a valve-like function of the cartilaginous ET; abnormal closure of this valve is now believed to underlie most cases of ET dysfunction. Misurya reported in 1976 on the "functional Eustachian tuboplasty," wherein the action of the tensor veli palatini was augmented by lessening the length of its tendon. Jansen described in 1985 a mucosal-sparing technique to resect the posterior portion of the ET. A handful of other techniques received little lasting attention.



Eustachian tube catheterization with a diagnostic tube in use. From Kramer's *Aural Surgery of the Present Day* (1863).

The most recent wave of innovations in ET surgery has been marked by the adaptation of current rhinologic techniques. In 1997, Kujawski introduced the laser Eustachian tuboplasty, whereby mucosa and cartilage were obliterated from the posterior wall of the ET. Metson et al subsequently reported on a transnasal endoscopic technique that entailed removal of mucosa from the torus tubarius using a tissue shaver. Modifications of the laser tuboplasty have also been described.

Current interest in ET surgery focuses on the cartilaginous portion of the ET as the site of pathology in ET dysfunction. The newest technique involves endoscopic-guided balloon catheter dilation, which builds upon previous efforts that have established the ET as a dynamic organ. Ongoing studies of the ideal intervention for ET dysfunction are likely to shape the treatment of this disorder in years to come.

Dr. McCoul's article is based on the paper presented at the Otolaryngology Historical Society meeting, September 12, 2011. If you are interested in presenting at the 2012 OHS meeting, September 10, in Washington, DC, or wish to join or renew as an OHS member, contact museum@entnet.org.

In Memoriam: AAO-HNS Acknowledges Member Deaths

The Academy is notified of deaths of members throughout the year through family members and other sources. The list is updated as Member Services learns about members who have passed. The Academy acknowledges the following member for his years of service to the profession of otolaryngology-head and neck surgery. Our sympathies go out to his family.

Gonzalo G. Obregon, MD; Sacramento, CA; University of Iowa Hospital and Clinics, 1969

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2012 Cochrane Scholars: Call for Applications

Auckland, New Zealand
Sponsored by SAGE

The AAO-HNS/F leadership and SAGE, publisher of *Otolaryngology—Head and Neck Surgery*, have identified a need to train otolaryngologists in the conduct and publication of systematic literature reviews. Systematic reviews have a high citation impact, and serve as the foundation for evidence-based practice guidelines, clinical performance measures, and maintenance of specialty certification.

Four travel grants of up to $3,500 will be offered for the 2012 Colloquium in Auckland, New Zealand, September 30 – October 2, 2012. The Colloquium features a full scientific program plus about 60 training and discussion workshops related to systematic review. In return for a travel grant to attend the meeting, the attendees must agree, in writing, to initiate and submit a systematic review to the journal for publication consideration within 12 months (by October 29, 2013).

Attendees will be introduced to the Cochrane Collaboration, the world leader in evidence summaries of healthcare interventions, and will learn state-of-the-art techniques for producing systematic reviews and meta-analyses. The AAO-HNS/F has partnered with the Ear, Nose and Throat Disorders Group of Cochrane to create this unique educational opportunity, which features personal interaction with **Martin J. Burton, DM, FRCS,** Director of the UK Cochrane Center, and with the staff and editors of the Cochrane ENT Disorders Group.

Attendees will be selected based on their prior experience, statement of interest, and proposed topic. We seek to achieve a balance of subject areas.

Requirements

- Residents are not eligible
- Applicants must be members of the AAO-HNS
- Applicants must submit the following information in a Word attachment:
  - Name, address (including e-mail), and AAO-HNS member number.
  - An up-to-date list of your peer-reviewed publications
  - What prior experience do you have with systematic reviews?
  - What prior experience do you have with statistics and evidence-based medicine?
  - Why are you interested in attending the Cochrane meeting (be specific, please)?
  - What subject areas or topics are you interested in reviewing if awarded a travel grant?
  - Do you understand (and agree to) the obligation to submit a properly conducted systematic review to *Otolaryngology—Head and Neck Surgery* within 12 months of attending the meeting?

Deadline: March 1, 2012

Please send the above information in a Word attachment, along with your current CV, via e-mail to Eileen Cavanagh, Managing Editor, Journal at ecavanagh@entnet.org no later than March 1, 2012. Hard-copy submissions will not be accepted.

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Kids ENT Health Month: Make Use of AAO-HNS Member Outreach Tools

Every year our academy continues to produce and respond to media in order to promote our specialty and the welfare of our patients. Highlights include materials such as the monthly mini-campaigns and the four official Academy Health Observances - Kids ENT Health Month, World Voice Day, Oral, Head and Neck Cancer Awareness Week, and Better Hearing and Speech Month. All this information is easily found on the website under the Members/Media Outreach section. This material is presented in a variety of formats that are readily available for our members to utilize in their offices and to disseminate to the media.

Kids ENT Health Month, the first official observance of the year, is celebrating its 10th anniversary this February. This year we are paying particular attention to the hazards of choking, focusing on lithium batteries. In this issue of the *Bulletin* **Scott Schoem, MD** , Chair, Section on Otolaryngology, American Academy of Pediatrics, addresses the serious nature of this hazard. Choking is one of the top causes of death to children and the widespread use of small lithium batteries is exacerbating an already dangerous situation. Dr. David Nielsen, CEO of our Academy, demonstrates the Academy's integrated efforts to respond to this problem. It is clear that we are the best advocates for our patients and our efforts to keep them safe and healthy requires not only our awareness of threatening problems so that we may provide excellent care but also educating our patients through media efforts so that they know when and where to seek help. I encourage everyone to read these articles and to go to our website for more information.

Wendy Stern, MD, Chair
Media and PR Committee

Dates to Remember

Feb. 15 Register for BOG Spring Meeting and OTO Advocacy Summit.

Feb. 17-18 Coding Workshops, Las Vegas, see www.entnet.org/conferencesandevents.

Feb. 20 Close of AAO-HNSF 2012 Annual Meeting & OTO EXPO Call for Oral and Poster Papers.

March 1 *Bulletin*; a focus on Sleep Disorders, and includes a summary of the new guideline on sudden hearing loss.

April 1 *Bulletin*; features the AAO-HNSF Annual Meeting & OTO EXPO.

April 12-15 ENT for the PA-C Westin Arlington Gateway Hotel Arlington, VA.

April 16 Millenium Society Early Housing and Registration for Annual Meeting Opens.

April 24-27 The Third Middle East Congress on Rhinology and Facial Plastic Surgery www.entnet.org/conferencesandevents.

April 26-28 10th International Otorhinolaryngology Head & Neck Surgery Congress www.entnet.org/conferencesandevents.

April 27-28 AAO-HNSF Coding & Reimbursement Workshop, Chicago.

May 1 General Registration opens for 2012 AAO-HNSF Annual Meeting & OTO EXPO.

May 6-8 BOG Spring Meeting and OTO Advocacy Summit.

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Visit www.entnet.org for more.

Update on Choking Hazards and Dangers of Ingesting Lithium Batteries in Children

Scott R. Schoem, MD
Chair, Section on Otolaryngology
Connecticut Children's Medical Center, Hartford, CT

Can you name the top 10 foods that pose the highest risk of choking hazards for young children? Can you name at least three? (The answers are at the end of the article.)

In 2001, 17,500 children aged 14 and younger were treated in emergency departments in the United States for choking with 60 percent of those events caused by food items. More than 160 children die each year from choking events.[1,2] Choking is the fourth leading cause of death in children just behind motor vehicle injuries, drowning, and fires.

Why are children under four at the greatest risk for choking? Although front teeth start to erupt at seven months, followed by first molars at 15 months and second molars by 26 months, children under four have not developed the sophisticated ability to chew, swallow, and breathe in a coordinated fashion.[3] Toddlers need to avoid difficult-to-grind foods such as nuts, seeds, raw carrots, and hard candies. Also, large chunks of apples and tubular foods that fit perfectly into the larynx like hot dogs and whole grapes need to be cut up before giving to toddlers.

Non-food items that present the greatest choking hazards include balloons, coins, small toy parts, pen caps, and marbles. Since 1972, the Consumer Product Safety Commission has monitored children's toys and established recalls. Through their efforts, since 1980, all toys that fit within a small-parts test cylinder of 1 and 1/4 inch must be labeled "for children over 3 years." National and state Public Interest Research Groups provide the valuable service each year before the winter holidays of publishing lists of new dangerous and toxic toys.

Numerous policy statements by the American Academy of Pediatrics, publications such as *Bright Futures*, and HealthyChildren.org all promote parental education and recommend that pediatricians counsel parents at six-month, 1-, 2- and 3-year well-checks on choking hazards.[4] SafeKids USA promotes patient safety and injury prevention including choking hazards. Plentiful resources are readily available for pediatricians, parents, and daycare centers. Yet, despite all these efforts, the rate of food-related choking hazards has not diminished over the past 20 years. In one study, 40 percent of parents did not realize that a whole grape was dangerous, 35 percent felt that hot dogs were safe, 30 percent did not identify raw carrots as a choking hazard, and 25 percent did not know the dangers of latex balloons. Clearly, otolaryngologists and pediatricians need a better strategy to directly educate parents, grandparents, and daycare centers and prevent future choking hazards.

Scott R. Schoem, MD

Another emerging and serious problem that needs to be addressed immediately is the hazard of ingested lithium-ion batteries. While their use in toys mandates a screw top or other protective device, there is no mandated protection of these batteries in common places such as remote controls and music cards. Since 1985, there have been more than 8,100 cases

of battery ingestion with 13 reported deaths.[5] Lithium ions move from the negative electrode (cathode) to the positive electrode (anode) during discharge with damage to the esophagus within two hours after reported ingestion. Although the "internal ring" sign may be visible on an A/P radiograph to distinguish a flat battery from a coin, this may go unrecognized with delay in removal leading to serious injury or death.[6]

Since the days of Chevalier Jackson and the Federal Caustic Poison Act of 1927, the American Academy of Otolaryngology–Head and Neck Surgery has been proactive in partnering with manufacturers to promote patient safety. When necessary, the Academy's legislative office will lobby to introduce and support legislation to protect consumers. Currently, the Academy, in partnership with the American Academy of Pediatrics, American Society of Pediatricians, American Broncho-Esophagological Association, and the Society for Ear, Nose and Throat Advances in Children, seeks to reduce choking hazards and to mandate battery fixation to protect against battery ingestion.

Answer: nuts, seeds, raw carrots, hot dogs, whole grapes, popcorn, meat and cheese chunks, hard candy, fruit chunks, peanut butter chunks, and chewing gum. [7]

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BOG Spring Meeting and OTO Advocacy Summit

Sujana S. Chandrasekhar, MD
Board of Governors, Chair

Please mark your calendars and join us for the **BOG Spring Meeting** and the **OTO Advocacy Summit** in Alexandria, VA, from Sunday, May 6 through Tuesday, May 8. In this important election year, we have a packed agenda with something for everyone.

Sunday's program will start with lunch and career discussions–explore opportunities in: academy leadership, private practice, academic practice, the military, the VA/public health, women in OTO, diversity, humanitarian outreach, and being a successful hospital board member. This session is designed for otolaryngologists in all career stages.

> Our BOG General Assembly will include committee and breakout session reports, as well as addresses from each of the two candidates for President-Elect.

Then, all are welcome to attend the BOG Committee meetings–learn what is going on, volunteer your ideas, join in the discussion.

Finally, there will be breakout sessions relating to "Entrepreneurship, Public Relations and Media Outreach, Using the Web and Social Media Effectively."

Our ENT PAC, the Academy's political action committee, has planned a lovely Sunday evening at the historic George Washington Masonic Memorial in Alexandria for cocktails, snacks, and legislative chitchat. Please contribute to our PAC and join in the event.

Monday will start off with breakfast and Society Information Sharing geared toward residents and fellows, but all are welcome to attend.

Our Keynote Speaker will be **Vicki LoPachin, MD**, Medical Director/CMO of North Shore University Hospital, the main hospital of the NSLIJ health system, which is one of the largest hospital systems in the United States. She will discuss: "The Brave New World: Hospitals, Healthcare Systems, and the Modern Otolaryngologist."

Another highlight on Monday will be a session called "Developing and Patenting Your Ideas," featuring **Eric Mann, MD**, from the FDA and **Rodney Perkins, MD**, a successful otolaryngologist entrepreneur.

Our BOG General Assembly will include committee and breakout session reports, as well as addresses from each of the two candidates for President-Elect.

At lunch, we will start off the 2012 OTO Advocacy Summit with a featured speaker, followed by advocacy training sessions in the afternoon to heighten your advocacy skills. Also, don't miss the "insider" updates from key Members of Congress and the AAO-HNS Government Affairs team.

Tuesday, we will storm the Hill! After a briefing breakfast, we will all visit Capitol Hill and have the uniquely American opportunity to interact with our legislators and their aides one on one, and discuss with them our concerns as otolaryngologists for the future of American healthcare. This is an amazing experience and one you should either have for the first time this year or use to re-new your Capitol Hill contacts from previous years.

I hope that you can attend the BOG Spring Meeting and the OTO Advocacy Summit, May 6-8. See you there!

Out with the Old, In with the New: The Revitalized ENT PAC

In today's uncertain political climate, one thing appears to be set in stone—healthcare will remain one of the nation's top domestic priorities for the foreseeable future. As a result, the Academy must remain diligent to ensure all our advocacy-related programs are robust and working efficiently on behalf of our members.

One of the lesser known, but critically important, facets of the Academy's advocacy programs is its political action committee, ENT PAC. Whether you are a current PAC "Investor" or someone who knows little about its purpose and applicable programs, ENT PAC has much to offer, and all Academy members are encouraged to learn more.

Following a record-setting 2009-2010 fundraising cycle, the ENT PAC Board of Advisors and staff wanted to continue its positive momentum by incorporating several strategic and operational changes into the PAC programming. As a result, 2011 was a big year for ENT PAC, with the revitalization of existing PAC programs coupled with the rollout of several new initiatives. Because of their success in 2011, all of the following initiatives will continue in 2012.

Encouraging 'Friendly' Competition: The ENT PAC State Fundraising and Membership Challenge

During the 2011 spring meeting of the Board of Governors (BOG), ENT PAC Chair **Marcella R. Bothwell, MD**, introduced a new initiative designed to increase PAC fundraising and membership by encouraging friendly competition between the states. The ENT PAC State Fundraising & Membership Challenge tracks PAC activity in each state based on four metric categories–percent participation, dollars raised, number of new members, and average contribution. It was the goal of the ENT PAC Board of Advisors to develop a program that would provide smaller states the opportunity to more fairly compete with their larger counterparts. Program standings were updated regularly throughout the year and made available to ENT PAC Investors via the PAC webpage, the News, *Bulletin*, and "The ENT Advocate" e-newsletter. The 2011 winners are listed on page 28.

Recognizing our Investors: The ENT PAC Leadership Club Giving Levels

Introduced in 2011, the ENT PAC Leadership Club giving-levels program is an initiative to better recognize the PAC's strongest supporters while also incentivizing current Investors to give at a higher level. The three-tiered program provides various benefits for members who make contributions of at least $365—just $1 a day. The benefits associated with the program increase at $535 (Capitol Club—$1 for every member of Congress) and $1,000 (Chairman's Club). To learn more about the Leadership Club program, visit the ENT PAC webpage at www.entnet.org/entpac (U.S. AAO-HNS member log-in required).

Knowledge is Power: The ENT PAC 'Investors Report'

ENT PAC is only as strong as you—its Investors. With that in mind, the ENT PAC Board of Advisors wanted to devise a way to provide more information about the PAC and its applicable programs to its strongest supporters. Unveiled in 2011, the ENT PAC "Investors Report" is a semi-annual newsletter printed as an

exclusive benefit for all members of the ENT PAC Leadership Clubs. Each edition of the report includes updated information about ongoing ENT PAC programs, as well as applicable political commentary. Given the importance of this new ENT PAC tool, an online copy of the July edition of the "Investors Report" was made available to all PAC-eligible members of the AAO-HNS.

A New Look and Feel: ENT PAC Wall Re-Designed

The ENT PAC Wall of Donors is one of the most prominent displays at each year's Annual Meeting. In order to promote and complement the various new or re-designed PAC programs, the 2011 ENT PAC wall was transformed into a two-sided panel display and lounge area for current PAC Investors. In addition to the annual display of PAC supporters, the wall also featured information about the new giving level program and State Fundraising Challenge. If you were unable to personally view the PAC wall in San Francisco, be sure to see it on its home turf at the 2012 Annual Meeting & OTO EXPO in Washington, DC.

Adding to the Agenda: New ENT PAC/Advocacy Programming at the 2011 Annual Meeting

Despite the always packed Annual Meeting agenda, the Government Affairs staff wanted to ensure that Academy members had plenty of opportunities to learn more about ENT PAC and other advocacy programs. In San Francisco, ENT PAC Investors were invited to attend the first-ever Investors Briefing & Legislative Update to learn first-hand about PAC programs and ongoing legislative efforts. In addition, members of the ENT PAC Chairman's Club were invited to an exclusive "thank you" luncheon featuring members of the ENT PAC Board of Advisors.

Still to Come: Enhanced ENT PAC Website

Efforts are underway to entirely redesign ENT PAC's web presence. Once complete, the ENT PAC webpage will be transformed into an interactive website designed to better serve our ENT PAC Investors by providing key information about ongoing programs, as well as applicable political updates. In addition, U.S. AAO-HNS members who are interested in learning more about ENT PAC prior to becoming an Investor will have access to important educational materials and answers to frequently asked questions. Stay tuned for updates about the website's progress and email suggestions about the type of information you would like to see to entpac@entnet.org.

Contributions to ENT PAC are not deductible as charitable contributions for federal income tax purposes. Contributions are voluntary, and all members of the American Academy of Otolaryngology-Head and Neck Surgery have the right to refuse to contribute without reprisal. Federal law prohibits ENT PAC from accepting contributions from foreign nationals. By law, if your contributions are made using a personal check or credit card, ENT PAC may use your contribution only to support candidates in federal elections. All corporate contributions to ENT PAC will be used for educational and administrative fees of ENT PAC, and other activities permissible under federal law. Federal law requires ENT PAC to use its best efforts to collect and report the name, mailing address, occupation, and the name of the employer of individuals whose contributions exceed $200 in a calendar year.

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 will be able to stay current on all the latest legislation dealing with issues, such as the flawed Sustainable Growth Rate (SGR) formula, medical liability reform, scope-of-practice battles, and efforts to repeal the Independent Payment Advisory Board (IPAB). Visit www.entnet.org/advocacy today.

A Look Ahead: What to Expect in the Second Session of the 112th Congress

Partisanship, political posturing, and elections—oh my! With the second session of the 112th Congress having convened last month, it is safe to say that 2012 will not be a legislatively rich year. Although, at press time, Congress has yet to resolve the looming 27.4 percent cut in Medicare physicians payments beyond this month, most of the key healthcare-related legislative efforts will remain unaddressed until after the November elections.

Despite what may look like a lackluster year for advancing many of the Academy's federal priorities, the legislative lull created by the upcoming elections actually provides an opportunity to focus on better educating Capitol Hill staff on key ongoing and/or upcoming issues.

Hill staffers can often act as a linchpin for advancing specific issues, so it is critically important they are well versed on the Academy's legislative priorities. In addition, Members of Congress have already signaled they will be soliciting input from the physician community regarding the future of the Medicare physician payment system.

The AAO-HNS Government Affairs team will be working in earnest throughout 2012 to ensure that we are well poised to aid in the advancement of the issues important to otolaryngology–head and neck surgery.

Election Central – Your Guide for 2012

With just nine months until the 2012 general elections, now is the time to review your voting status and become well versed on primary dates in your state. To ensure AAO-HNS members have as much information as possible, the Government Affairs team has revived its "Elections" webpage (www.entnet.org/politics). Academy members are encouraged to visit the webpage to learn more about:

- Physician candidates for Congress;
- Current polling statistics;
- Primary dates;
- Voter registration information; and
- Much, much more!

Cosmetic Medical Procedure Taxes: an Ongoing Concern

Across the nation, many states are facing looming deficits and must act to address their current or impending budget crises. Many states have chosen to address these deficits with proposals for new taxes. With the 2011 sessions, there was a reemergence of states looking to tax cosmetic medical procedures to address budget shortfalls. Unfortunately, this trend is likely to continue into the 2012 sessions.

In 2011, a number of states (Connecticut, Minnesota, Texas, and Washington) proposed bills to adopt a tax on cosmetic medical procedures, with Connecticut being the only state to ultimately approve such a proposal. The state's final budget package included a 6.35 percent cosmetic medical procedure tax that was strongly opposed by the AAO-HNS, American Academy of Facial Plastic and Reconstructive Surgery, and others in the Stop Medical Taxes Coalition—a coalition of national, state, and local organizations. The legality of this budget provision is already being called into question by the state, primarily due to the logistics of collecting the tax and concerns regarding patient privacy.

> "With the 2011 sessions, there was a reemergence of states looking to tax cosmetic medical procedures to address budget shortfalls."

Prior to Connecticut's adoption, New Jersey had been the only state to implement a tax on cosmetic medical procedures. In 2004, New Jersey passed a 6 percent tax on elective cosmetic medical procedures. Since enactment, the state's Department of Taxation has experienced an estimated 59 percent shortfall based on its projected revenue estimates. According to independent studies, for every dollar New Jersey collects on the tax, the state loses $3.39 in total revenue. As a result of this failed tax, New Jersey Assemblyman Joseph Cryan, the sponsor of the 2004 bill, led efforts to repeal the tax in his state and communicated this negative experience to elected officials across the country. The New Jersey legislature continued to work on repealing the tax, with the most recent effort in 2011 resulting in the Governor signing the repeal of the cosmetic medical procedures tax.

As the 2012 state legislative sessions move forward, the AAO-HNS will closely monitor the implementation of the new tax in Connecticut and continue to work with the Stop Medical Taxes Coalition to develop comprehensive strategies to defeat proposals on the taxing of cosmetic medical procedures.

Attention New York Members: State Lobby Day: Save the Date

The New York State Society of Otolaryngology-Head and Neck Surgery (NYSSO) will conduct its annual State Lobby Day in conjunction with the New York Coalition of Specialty Care Physicians on Tuesday, May 15 in Albany.

In past years, the NYSSO has focused significant time and resources on advocating for the repeal of an outdated and unnecessary state law that prevents New York otolaryngologists from a benefit enjoyed by thousands of their colleagues across the country—the ability to dispense hearing aids for a profit. The NYSSO is committed to redoubling its efforts and insuring passage of a repeal bill in the 2012 legislative session, but it needs the active support and participation of all ENTs in New York to achieve this goal.

The State Lobby Day will kick off with a morning issue briefing in the Legislative Office Building. Immediately following the briefing, otolaryngologists will join colleagues from other surgical specialties on visits with State Senate and Assembly Representatives to present their positions on specialty-specific legislation (e.g., the hearing aid access bill), and pending bills of importance to the medical community as a whole.

A good turnout is critical to our ability to effectively advocate for our patients and our profession, so all New York otolaryngologists are urged to mark their calendars, clear their schedules, and plan to be in Albany on May 15. For additional details and a registration form, please contact the NYSSO office at (518) 439-2020 or nyssohns@aol.com.

State Advocacy Resources at Your Fingertips

In 2011, the AAO-HNS was successful in advocating on a number of proposed bills. That success is attributable to our members and their outstanding advocacy efforts on behalf of the specialty. Your continued assistance and leadership is crucial in 2012, so below are a few resources to aid in ongoing advocacy efforts:

- The AAO-HNS tracks hundreds of bills each year that have been identified as bills of potential interest to the specialty and our members. This information is available on the website at www.entnet.org/practice/members/stateadvocacy.cfm. An additional resource to help our members stay informed and connected to the legislation in their state is through customizable state legislative tracking reports that are sent directly to your email inbox.
- The ENT Advocacy Network provides members with bi-weekly email updates on key state and federal legislative and political developments, as well as important "action alerts" where assistance is needed on key legislative proposals. This is a free member benefit, and joining is simple at www.entnet.org/advocacy.
- Are you involved in, or a leader for, your state medical society and/or its committees? Your key contacts enable the AAO-HNS to stay connected and/or support critical activities at the state level. Please email legstate@entnet.org to share your contact information so we may use you as a resource and conduit to your state medical society.

With questions, information, or interest in any of these resources, please contact legstate@entnet.org.

Advocate at a Higher Level — Attend Our 2012 OTO Advocacy Summit

Help increase our visibility and influence on Capitol Hill by attending the 2012 OTO Advocacy Summit. Planned in conjunction with the spring Board of Directors and Board of Governors meetings, this year's advocacy summit is scheduled for May 7-8, so mark your calendar today. OTO Advocacy Summit attendees will participate in legislative advocacy training sessions and can take advantage of pre-scheduled meetings with Members of Congress and/or their staffs. There will also be ample networking events and an exclusive ENT PAC fundraiser. Please note there will not be a Joint Surgical Advocacy Conference in 2012, so don't miss this unique opportunity to heighten your advocacy skills on Capitol Hill and be a leader for the specialty. Registration opens this month, check www.entnet.org.

Alphabet Soup: Acronyms You Need to Know to Be an Effective Advocate for the Specialty

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

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

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

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

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

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

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

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

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

Looking Forward in the States in 2012

In 2012, all but four states will convene in regular session and file more than 100,000 bills. Although state economies are improving, state budgets are still a main focus in legislatures around the country. However, some lawmakers continue to address the important ongoing issues impacting the healthcare sector.

This year, the Academy will continue to closely monitor legislative proposals that could influence the practice of medicine, and in particular, the practice of otolaryngology-head and neck surgery. Some of the bill topics being tracked by the AAO-HNS include scope of practice, newborn hearing screening, taxes on medical services, hearing aid dispensing, medical liability reform, payment, and truth in advertising. This session, Academy members should expect a heightened number of scope-of-practice battles and cosmetic medical procedure tax proposals as states try to identify alternate funding and patient care models. Additionally, in many statehouses, the implementation of national healthcare reform and proposed healthcare delivery models will be a top priority.

To learn more about what the AAO-HNS is tracking in your state and across the country, you can view a complete online listing of the bills being tracked visiting www.entnet.org/practice/members/stateadvocacy.cfm.

Online state legislative tracking reports can be tracked by state or legislative issue, and customized legislative reports are available to state society leaders. To request a customized report for your state or to ask questions, email legstate@entnet.org.

The Results Are In: Where Does Your State Rank?

The books are closed, and the results are in for the inaugural ENT PAC State Fundraising and Membership Challenge. See the box to find where your state finished and learn more about how you can increase your ranking in 2012.

Last year, the ENT PAC Board of Advisors introduced a new program—the ENT PAC State Fundraising and Membership Challenge—with the hope of encouraging friendly competition and support of one of the Academy's most important advocacy tools, ENT PAC. Based on the principles of "peer-to-peer" solicitation, the program measures ENT PAC calendar year activity in each state. By measuring the states in four metric categories—percent participation, number of new members, dollars raised, and average contribution—smaller states are afforded the opportunity to compete more fairly with their larger counterparts.

The ENT PAC Board of Advisors hopes that the peer-to-peer component of the program will add a new layer of personal involvement in, and ownership of, our general PAC programs. The success of this type of solicitation is due, in part, to the reality that the average person is more likely to give to and/or support a program if they are asked personally to contribute by someone they know, admire, and/or respect.

Results are already being tabulated for 2012, so now is the time for you to act and encourage your state colleagues to engage. To view the current standings, visit the ENT PAC webpage at www.entnet.org/entpac (AAO-HNS log-in required).

If you are interested in receiving more information about how your state can increase its rankings, contact ENT PAC staff at entpac@entnet.org.

2011 Results

Percent participation – Montana – 15%
Number of new members – Florida – 17
Dollars raised – New York – $21,095
Average contribution – Nebraska – $1,018

**Contributions to ENT PAC are not deductible as charitable contributions for federal income tax purposes. Contributions are voluntary, and all members of the American Academy of Otolaryngology-Head and Neck Surgery have the right to refuse to contribute without reprisal. Federal law prohibits ENT PAC from accepting contributions from foreign nationals. By law, if your contributions are made using a personal check or credit card, ENT PAC may use your contribution only to support candidates in federal elections. All corporate contributions to ENT PAC will be used for educational and administrative fees of ENT PAC, and other activities permissible under federal law. Federal law requires ENT PAC to use its best efforts to collect and report the name, mailing address, occupation, and the name of the employer of individuals whose contributions exceed $200 in a calendar year.*

2011 ENT PAC Investors Recognition and Appreciation

Thanks to the generous contributions of U.S. AAO-HNS members and staff, ENT PAC – the Academy's political action committee – had another strong fundraising year. As long as healthcare reform remains one of the most important issues being discussed by Congress, it is particularly vital that advocacy tools, such as the ENT PAC, are utilized to their full capacity. The strength of ENT PAC, specifically the number of donors and size of our coffers, helps determine the strength of our voice on Capitol Hill!

The ENT PAC Board of Advisors thanks all U.S. AAO-HNS members and staff who helped to make a difference in 2011 by supporting ENT PAC!

If you would like additional information about ENT PAC and its programs, please contact entpac@entnet.org.

2011 Chairman's Club Investment of $1,000+ Annually

Andover ENT Center, Inc.
J Noble Anderson, MD
William Bauer, MD
Daniel Berner, MD
William Blythe, MD
Marcella Bothwell, MD
Karen Calhoun, MD
C Y Chang, MD
Richard Collie, DO
Susan Cordes, MD
Eduardo Diaz, MD
Lee Eisenberg, MD, MPH
Cameron Godfrey, MD
Joseph Hart, MD, MS
Paul Imber, DO
Ronald Kirkland, MD
Timothy Knudsen, MD
Alice Kuntz, MD
Steven Levine, MD
Rodney Lusk, MD
J Scott Magnuson, MD
Theodore Mason, MD
William Merwin, MD
Samantha Mucha, MD
David Nielsen, MD
Rick Odland, MD, PhD
George Parras, MD
Anna Pou, MD
Robert Puchalski, MD
Richard Rosenfeld, MD, MPH
Michael Seidman, MD
Gavin Setzen, MD
Adam Shapiro, MD
Paulus Tsai, MD
Edwin Williams, MD
Jay Youngerman, MD
Jan Youssef, MD

2011 Capitol Club Investment of $535+ Annually

Carlos Benavides, MD
David Boisoneau, MD
Richard Brauer, MD
James Brawner, MD
Jeffrey Brown, MD
Sujana Chandrasekhar, MD
Jonathan Cooper, MD
Anthony Cornetta, MD
John Donovan, MD
Randy Folker, MD
Nancy Griner, MD
Joseph Hoang, MD
John House, MD
Stacey Ishman, MD
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Patient Management Perspectives in Otolaryngology: New Name, Same Patient Focus

Daniel J. Kirse, MD, Editor, **Patient Management Perspectives in Otolaryngology**
Professor and Vice-Chair Department of Otolaryngology-Head and Neck Surgery, Wake Forest University School of Medicine

The Patient of the Month Program (PMP) began at the AAO-HNSF in 1971 and has published 41 volumes and more than 300 individual issues under the leadership of several editors, including **William W. Shockley, MD, Charles M. Myer, MD,** and **J. Dale Browne, MD,** along with countless volunteer expert authors and reviewers. I have had the pleasure of serving as editor since 2008. The Foundation has been working with Decker Publishing on this official Academy publication since 1988.

During a 40-year period, PMP has evolved into a Foundation standard offering otolaryngologists the opportunity to hone decision-making skills and improve patient care. Published eight times a year, PMP guides the reader through the full management of an individual patient from evaluation to diagnosis, treatment, and outcomes in an interactive question-and-answer format with immediate feedback from expert authors. Each issue addresses a critical and timely clinical case study in one of the eight specialty areas of otolaryngology, authored by the talented and dedicated members of the Foundation education committees.

In order to emphasize the patient focus and to better reflect the goal of the publication, the name has been changed to *Patient Management Perspectives in Otolaryngology,* still affectionately known as PMP. The first volume with the new title began in fall 2011 with an issue on "Adult with Acute Laryngeal Trauma." A free copy of this issue can be found with this month's *Bulletin* for members to see what a wonderful education resource PMP can be and to encourage your subscription today.

> "Published eight times a year, PMP guides the reader through the full management of an individual patient from evaluation to diagnosis, treatment, and outcomes in an interactive question-and-answer format with immediate feedback from expert authors."

The primary audience for PMP is physicians and physicians-in-training who specialize in otolaryngology. Overall outcome objectives for the activity are to increase knowledge of the most current research advances and medical practices in otolaryngology; maintain greater competence in performing diagnostic and treatment measures to provide quality service to patients; and improve practice skills, abilities, and strategies for high-quality, evidence-based standards of otolaryngology healthcare delivery.

Daniel J. Kirse, MD

PMP is available in both print and digital delivery formats. However, I must admit, while the print version is convenient, the online version offers a much richer education experience through the expert use of multimedia. I encourage you to consider subscribing to the online version today.

I hope you enjoy this free look at one of the Foundation's oldest and most popular education products. With the name change comes a renewed sense of dedication to PMP through focused and timely content critical to the evolving field of otolaryngology practice.

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Everyone's Keeping Score These Days

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

The use of metrics has long been a part of business culture. Certainly, hospitals have similarly utilized scorecards to measure such metrics as their financial operations and their efficiency with intra-hospital and peer comparisons. Recently, scorecards have started being rolled out or mandated to measure quality improvement as well as physicians' outcomes. Many hospitals have quality improvement dashboards or scorecards. These are kept at a high level and usually do not report on individual physician outcomes.

However, as mandated by the Joint Commission, the Ongoing Professional Practice Evaluation (OPPE) is ultimately a physician scorecard. Medical staffs have the freedom to design these with certain elements that are compulsory categories, such as attempting to follow the ACGME's six core competencies.

The role of these physician performance scorecards, as envisioned by the regulatory agencies, is to be able to instantly compare physicians within departments and intra-hospital as well as between different hospitals. This will produce an estimation of the clinical care delivered by the physician and a comprehensive review of their outcomes. Imagine in our current state that a hospital can really only know about a physician's performance at their hospital. If a physician is having poor outcomes or taking sicker/higher risk patients to another institution (for whatever reasons), it may not be noticed by the other hospitals.

We can consider that as the power of technology grows and the ability to aggregate such data becomes rapid and easy, these scorecards will become extremely sophisticated. Currently, many hospitals and medical staffs are struggling with rolling out the OPPE as the beta version or the initial live version. The Joint Commission mandates that the OPPE is conducted twice a year; so in the next year and a half, most medical staffs will be moving on to OPPE version three or four! The sophistication of these scorecards and thus, their inherent utility will become quite apparent.

> "The physician scorecards provide much needed data to department chairs and administrators regarding trends in physician performance, outcomes, and case volumes. A Focused Professional Practice Evaluation (FPPE), which is an analysis of a recent outcome or areas of concern for a physician, can be more easily performed with the setting of robust scorecards."

Furthermore, the physician scorecards provide much needed data to department chairs and administrators regarding trends in physician performance, outcomes, and case volumes. A Focused Professional Practice Evaluation (FPPE), which is an analysis of a recent outcome or areas of concern for a physician, can be more easily performed with the setting of robust scorecards.

In this column, we often speak about metrics that matter with respect to how we as otolaryngologists define metrics that track our own outcomes. The onus of the Joint Commission OPPE is that the burden rests on us to ensure that the metrics we are describing and setting up are consistent, measurable, and actionable. As OPPE and scorecards evolve, the strength of the defined metrics will grow and the need to not only define strong specialty-specific metrics, but also global metrics (those not specialty-specific) will grow.

A crucial aspect of scorecards is their ability to provide hospital administrators and department chiefs with instant ability to analyze their providers for potential over-use measures. This is an area with significant exposure risk for surgeons. There have been high-profile, multi-million dollar settlements with hospitals based on surgeons' over-use of specific procedures. An outcomes scorecard may not have prevented this from occurring, but such procedural bias or significant deviance from the averages in a hospital or department may have been much more apparent in the setting of a six-month cycled OPPE or scorecard.

We anticipate in the coming years that outcome scorecards for physicians to demonstrate and measure the quality of care they deliver will emerge as a real force for medical staffs and will certainly be a tool to help us improve and show the quality of care that we deliver.

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.

CPT 2012 Code Update for Otolaryngology: An Overview of Evaluation and Management Code Changes

Kim Pollock, RN, MBA, and Mary LeGrand, RN, MA

There are several Current Procedural Terminology® (CPT) code changes for 2012 applicable to otolaryngologists. This article provides a high-level overview of Evaluation and Management (E/M) code changes and is not meant to be an all-inclusive discussion.

Evaluation and Management Services Guidelines

The new and established patient definitions in the Evaluation and Management Guidelines were revised to again include the statement "A new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years." Additionally, CPT now says "An established patient is one who has received professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice within the past three years."[1]

While CPT reintroduces these statements (deleted in 2011) of reporting a new patient code when your partner of a different subspecialty sends you a patient, the guidelines offer no specific definition as to what constitutes a "specialty" and "subspecialty." The new patient versus established patient decision tree, also removed in 2011, has returned to the CPT codebook to illustrate the point. This, however, leaves otolaryngologists in a quandary. Can you, Dr. Neuro-otologist, report a new patient code (9920x) when your partner, Dr. Head and Neck sends you a patient? The CPT changes for 2012 lead you to believe so, although CPT offers no definition of specialty/subspecialty or even a specific example of a specialty/subspecialty.

However, Medicare and many other payers identify physicians according to their specialty rather than fellowship-training or board certifications subspecialty. In otolaryngology, Medicare does not have any separate subspecialty codes as they do for other specialties, such as orthopaedic surgery. Although CPT directs users to consider the physician's subspecialty when choosing a new or established patient E/M code, again, CPT does not define the terms specialty and subspecialty. Furthermore, the vast majority of payers do not recognize physician subspecialties, such as those pertinent to otolaryngology (e.g., neuro-otology, rhinology, and laryngology).

Check with your payers to determine their policy on this issue and report accordingly.

Initial Observation Care

The typical time allocated for each of the three initial observation care codes, 99218-99220, was added to each code's description.

Refer to the CPT codebook for specific new guidelines for the prolonged services codes.

Modifier 33 (Preventive Services)

This modifier has been effective since January 1, 2011, but was not included in CPT until the 2012 version. The Patient Protection and Affordable Care Act (PPACA) requires all healthcare insurance plans to begin covering preventive services and immunizations without any cost-sharing. Modifier 33 allows providers to identify for insurance payers that the service was preventive under applicable laws and patient cost sharing does not apply. In other words, co-pays or deductibles are not collected for services covered under this law.

The U.S. Preventive Services Task Force (USPSTF) A and B preventive service recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm, accessed November16, 2011) applicable to otolaryngology include:

- Hearing loss screening in newborns,
- Tobacco use counseling and interventions: non-pregnant adults, and
- Tobacco use counseling: pregnant women.
- For more information about modifier 33, refer to the CPT Assistant, December 2010.

Summary

It is important for otolaryngologists and their support staff to stay abreast of CPT changes. We recommend annual attendance at an Coding and Reimbursment Workshops. The 2012 course dates and locations are listed in the table below. Please visit http://karenzupko.com/workshops/otolarngology/index.html for more information.

Reference

1. 2012 Current Procedural Terminology Changes An Insider's View, American Medical Association

Kim Pollock and Mary LeGrand are senior consultants at KarenZupko & Associates, Inc. (www.karenzupko.com), a physician practice management and training consulting company based in Chicago, IL. Both are instructors for the AAO-HNSF Coding and Reimbursment Workshops and long-time affiliate members of the Academy.

Note These 2012 Course Dates

January 20-21 ..... Southlake (Dallas), TX
February 17-18 ..... Las Vegas, NV
March 9-10..... Orlando, FL
April 2-7-28 ..... Chicago, IL
August 17-18 ..... Nashville, TN
September 21-22 ..... Baltimore, MD
October 26-27 ..... Costa Mesa, CA
November 16-17 ..... Chicago, IL

CPT 2012 Code Update for Otolaryngology-Related Services

Kim Pollock, RN, MBA, and
Mary LeGrand, RN, MA

There are several Current Procedural Terminology® (CPT) code changes for 2012 applicable to otolaryngologists. This article provides a high-level overview of CPT code changes and is not meant to be an all-inclusive discussion.

Integumentary System

Skin, Subcutaneous, and Accessory Structures

The guidelines were revised to direct users to append modifier 59 (distinct procedural service) with either code 11042 or 11044, as appropriate, and the instruction to append modifier 59 to the add-on codes was deleted.

Repair (Closure)

Refer to the CPT codebook for specific guideline changes related to wound repairs. A significant change is the instruction to use modifier 59 when more than one code classification of wounds is reported. CPT states to "list the more complicated repair as the primary procedure and the less complicated as the secondary procedure, using modifier 59" rather than modifier 51 (multiple procedures) as was historically used.[1]

Skin Replacement Surgery

Significant changes were made to this subsection of the CPT codebook. The changes include deletion of 24 codes, revision of six codes, and the creation of eight new codes (15271-15278). The old codes (e.g., 15330) were intended to be used for skin replacement, though there was much confusion about this among physicians and coders.

The new codes are defined by the anatomic location, the surface area size in square centimeters (the first 25 or 100 sq. cm), and then an associated add-on code for each additional 25 sq. cm or 100 sq. cm as appropriate for the anatomic location and wound surface area size. Refer to the CPT codebook for a comprehensive listing.

These new codes apply to non-autologous human skin (dermal or epidermal, cellular or acellular) grafts (e.g., homograft, allograft), non-human skin substitute grafts (i.e., xenograft), and biologics that form a sheet scaffolding for skin graft. The graft is anchored using the surgeon's fixation of choice, however CPT codes 15271-15278 do not apply to products that are non-graft wound dressings, such as gel, ointments, foam, or liquid.

While otolaryngologists may not commonly perform the above-noted skin replacement procedures, they will use a new code that resulted from these code changes. CPT 2012 introduced a new biological implant add-on code, +15777, *Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (e.g., breast, trunk) (List separately in addition to code for primary procedure).*

Many otolaryngologists will likely use this code to provide soft tissue reinforcement to a defect (e.g., parotid, temporal) prior to skin closure.

Action Steps:

- Use +15777 to accurately report biologics that are not skin replacement, but where the biologic is used for soft tissue reinforcement.
- Report +15777 in addition to a primary procedure code; do not report it as a stand-alone procedure code.
- Do not append modifier 51 to +15777 because it is an add-on code and modifier 51 is not applicable.

- Expect 100 percent of the allowable to be reimbursed because it is an add-on code and should not be reduced for multiple procedures (modifier 51).

Hemic and Lymphatic Systems

A revision to CPT +38746 in the Lymph Nodes and Lymphatic Channels subsection has implication for otolaryngologists. This add-on code has been revised to state Thoracic lymphadenectomy by thoracotomy, mediastinal, and regional lymphadenectomy (List separately in addition to code for primary procedure). Therefore, this code now requires the performance of a thoracotomy in order to be reported.

Additionally, 38792 was revised to state *Injection procedure; radioactive tracer for identification of sentinel node* to clarify that this code should be reported only for injection of a radioactive tracer for sentinel node identification.

Auditory System

CPT 69802

(*Labyrinthotomy, with perfusion of vestibuloactive drug(s); with mastoidectomy*) was deleted because this procedure has become obsolete.

Medicine: Special Otorhinolaryngologic Services

Audiologic Function Tests

CPT 2012 brings a new otoacoustic emission code (OAE) for automated analysis of OAEs, and the existing two codes have been revised. Below is a comparison of the 2011 and the 2012 CPT code descriptors.

2011/2012

92587

2011

Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)

2011

Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, three to six frequencies) or transient evoked otoacoustic emission, with interpretation and report

92588

2011

Comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)

2012

Comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report

92558

2011

Code did not exist

2012

Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis

The new code, 92558 (not to be confused with existing code, 92588), was developed to describe the automated testing of screening evoked otoacoustic emissions. Notice that the new code, 92558, has the # symbol prior to the code to show that this code is out of numerical sequence in the CPT codebook.

Medicare's non-facility (physician office, place of service 11) relative value units (RVUs) for the existing codes, and the new code, are listed in the table below.

CPT Code	`2011 RVU-NF`	2012 RVU-NF
92587	1.09	0.83
92588	1.95	1.26
92558	NA	0

Medicare considers the new code 92558 a "statutory exclusion" from the Medicare Physician Fee Schedule and will not reimburse for this service because it is a screening, automated analysis test. While this type of testing will likely not be performed on a Medicare patient, other payers may not reimburse due to Medicare's policy. Check with your payers for their policies.

Evaluative and Therapeutic Services

CPT 92605 (Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour) was revised to include the time component in the descriptor. Additionally, a new add-on code, +92618 (*Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes* [List separately in addition to code for primary procedure]), was created to account for time spent face-to-face with the patient beyond one hour.

Finally, 92621 (Evaluation of central auditory function, with report; each additional 15 minutes [List separately in addition to code for primary procedure]) now includes the + symbol prior to the code to reflect the status of this code as an add-on code.

Medicine: Neurology and Neuromuscular Procedures

Sleep Medicine Testing

The guidelines for this subsection have been updated and should be reviewed by any otolaryngologist who performs sleep testing (attended or unattended). There were two new unattended sleep study codes, 95800-95801, in CPT 2011.

Summary

It is important for otolaryngologists and their support staff to stay abreast of CPT changes. We recommend annual attendance at an AAO-HNSF Coding and Reimbursment Workshops. The 2012 course dates and locations are listed in the table below. Please visit http://karenzupko.com/workshops/otolarngology/index.html for more information.

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Reference

1. 2012 Current Procedural Terminology Changes An Insider's View, American Medical Association

2012 OIG Work Plan: Initiatives of Interest to Otolaryngology

On October 5, 2011, 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 in an effort to promote efficiency; and eliminate incorrect billing, waste, fraud and abuse in these programs. The OIG releases the details of their findings in reports that outline their methodology for determining payment, or billing errors, and recommendations to the Centers for Medicare and 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 their selection of new areas to audit in Medicare Part A and 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 their oversight of the Recovery Act, the OIG will also review several initiatives and programs created under the Affordable Care Act (ACA).

> "The OIG plans on focusing 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."

We have reviewed the 2012 work plan and believe the following new OIG initiatives may impact otolaryngologists – head and neck surgeons. Members should also remember that several initiatives instituted last year are still ongoing. Some of the new areas that OIG will review in 2012 are:

- OIG will review the accuracy of Present-On-Admission Indicators submitted with Medicare claims by hospitals. Indicators identifying which diagnosis was present at the time of admission are required by Medicare to indicate diagnoses that were present at the time of admission versus those that developed during the hospital stay. As the ACA provides, hospitals with high rates of hospital-acquired conditions (HAC) will receive reduced payments.
- Due to the significant rise in surgeries and procedures performed in ambulatory surgical centers and hospital outpatient departments during the past decade, OIG will closely assess the safety and quality of care provided in these settings, identifying and comparing any adverse events in both settings.
- OIG will continue its review of 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. The global surgery period includes a surgical service and related preoperative and postoperative E/M services. Prior OIG work has shown improper use of modifiers during global surgery periods, resulting in inappropriate payments and therefore, OIG has taken the initiative to review the appropriate use of certain claims modifier codes during the global surgery period.
- OIG has commenced and will continue reviewing the extent that physicians are opting out of Medicare and determine whether physicians who opt out are still submitting claims to Medicare.
- OIG will review physician billing for "incident-to" services, or services rendered by a non-physician that are billed by the physician as incident to an office visit, to determine whether payment for such services had a higher error rate than that for non-incident-to services. They will also assess CMS' ability to monitor services billed as "incident-to."
- Given its goal to eliminate fraud, abuse, and incorrect billing, OIG will review payment systems controls that identify high cumulative Medicare Part B payments to physicians and suppliers. A high cumulative payment is usually made on behalf of an individual beneficiary during a specified period.

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.
- Medicare payments for observation services provided during outpatient visits.
- 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.
- E/M Services to determine whether coding patterns vary by provider characteristics.
- 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)
- Medicare Part B claims that providers bill as "not reasonable and necessary" services (identified by modifiers GA or GZ)
- Appropriateness of providers' use of modifier GY (services that are not covered by Medicare)
- 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 CPT Codes for ENT physicians in 2012 (http://www.entnet.org/practice/Guidelines.cfm) prior to submitting your claims.

Please email Healthpolicy@entnet.org for further inquiries.

Reference

1. Office of Inspector General 2012 Work Plan. http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/Work-Plan-2012.pdf

AAO-HNS Comments: 2012 Medicare Physician Fee Schedule Final Rule

The 2012 final rule for the Medicare Physician Fee Schedule was put on public display on Nov. 1, 2011, and was published in the Nov. 28, 2011, issue of the *Federal Register*. Within the final rule, there were many issues the Academy commented on to the Centers for Medicare and Medicaid Services (CMS) in August 2011 for the interim rule and in January for the final rule. These comment letters can be found on the Academy's website at http://www.entnet.org/Practice/Summaries-of-Regulations-and-Comment-Letters.cfm.

Payment

The final rule included a projected conversion factor of $24.6712 (compared to the 2011 $33.9764 conversion factor), which was a reduction of 27.4 percent. The Academy strongly urged Congress to act and overturn the proposed cuts to physician payments.

In late December, the Congress passed a short-term patch preventing payment reductions until March 1st, but the Academy is concerned that if there is no long-term fix passed this year in Congress and only temporary short-term patches are considered, the result could be an interruption in claims processing by CMS.

The Academy commented on four RVUs for CY 2012 that CMS amended, 15732 *Muscle-skin graft head/neck, 42415 Excise parotid gland/lesion, 42440 Excision of submandibular (submaxillary) gland, and 60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy.* In comments, the Academy urged CMS to restore the physician work values to the 2011 work RVUs. In the final rule, CMS adjusted the RVU of site of service anomaly codes that current Medicare PFS claims data show are furnished more than 50 percent of the time as outpatient services, saying physician outpatient work following a 23 hour stay is less intense than inpatient work and therefore believe the valuation of the codes that fall into the 23 hour stay category should not reflect physician work associated with inpatient service.

CMS also reduced the practice expense values for the CPT codes for nasal/sinus endoscopy with balloon dilation (*CPT codes 31295, 31296 and 31297; new codes effective January 1, 2011*) by reducing the sinus surgery kit to 0.5 for all three codes on an interim basis for 2012.

In August 2011, the Academy disagreed with the review of 91 evaluation and management (E/M) codes; and 70 high PFS expenditure procedural codes (those with CY 2010 allowed charges of greater than $10 million at the specialty level) that have presumably not been reviewed since CY 2006 and do not reflect current medical practice. In the final rule, CMS did not finalize the list, but will instead wait to assess how to value these codes.

In 2012, CMS will end the practice of conducting separate and "freestanding" Five-Year Reviews of work and PE RVUs, and instead consolidate these reviews with the ongoing annual reviews of potentially misvalued codes, as well as focusing on only active codes covered by Medicare. The Academy supported CMS in the proposal to consolidate reviews, similar to what the AMA RUC does with continuous review.

Physician Quality Reporting System (PQRS)

There is a .5 percent incentive payment for successful participants in the PQRS in 2012, which includes three options for participants to report individual measures, claims, registry, and EHR, and two options for reporting measure groups, claims, and registry. The rule also includes a 1.5 percent penalty in 2015 for physicians who do not satisfactorily report in the 2013 reporting period.

CMS finalized the proposal to lower the reporting threshold from 80 to 50 percent of the eligible professional's Medicare Part B PFS patients seen during the reporting period to which the measure applies. The Academy appreciated CMS finalizing this change.

Asthmas and Perioperative Care were retained as measure groups and Sleep Apnea (registry-based reporting only), Assessment of Sleep Symptoms, Severity Assessment at Initial Diagnosis, Positive Airway Pressure Therapy Prescribed, and Assessment of Adherence to Positive Airway Pressure Therapy were added as measure groups. In comments to CMS, the Academy expressed its appreciation in CMS' addition and retention of these measure groups.

CMS will continue to provide feedback reports on claims reporting. EHR and registry vendors will have to provide interim reports based on services provided from January through March of 2012, as well. CMS will offer .5 percent incentive payment for MOC program participants. In comments, the AAO-HNS expressed concerns about the requirements for participation.

Professionals and group practices may request an informal review of the determination that they did not satisfactorily submit data on quality measure under PQRS through a web-based tool and CMS must provide a response within 60 to 90 days.

CMS plans on issuing an interim rule in 2012 prior to the initial performance period in 2013 for the application of value-based payment modifiers under the physician fee schedule starting in 2015. According to CMS, this calendar aligns with EHR and PQRS, allowing physicians to join these programs, begin to report quality measures, and increase the quality of care. In our comment letter, the Academy expressed concerns that efficiency measures were not adequately defined and recommended that CMS gather stakeholder input before developing quality measures for the value-based modifier.

If you have questions about the 2012 Medicare Physician Fee Schedule, please email the Health Policy team at healthpolicy@entnet.org.

Avoid Being Put on the RAC: Be Prepared for a Recovery Audit Contractor Review

Any medical practice submitting claims to a government program, such as Medicare, may contend with a Recovery Audit Contractor (RAC). RAC audits are not one-time or intermittent reviews—they are a systematic and concurrent operating process for ensuring compliance with Medicare's clinical payment criteria, documentation, and billing requirements.

The Medicare RAC program was signed into law as part of the Medicare Prescription Drug Improvement and Modernization Act of 2003 and made permanent by the Tax Relief and Health Care Act of 2006. Its purpose is to identify improper Medicare payments—both overpayments and underpayments—nationwide. In three years of RAC audits, auditors have identified nearly $1 billion dollars in overpayments.

The RACs use proprietary software programs to identify potential payment errors in areas such as duplicate payments, fiscal intermediaries' mistakes, medical necessity, and coding. RACs also conduct medical record reviews. Implementing appropriate compliance plans now will reduce anxiety and uncertainty if you are subjected to an audit.

Assign a staff member the job of implementing a compliance plan, or consider hiring a contractor for this task. The person responsible for implementing the plan should regularly:

- Review denied claims categories during the RAC demonstration program.
- Keep abreast of notifications on the CMS website.
- Review the annual Office of Inspector General (OIG) Work Plan document to assist providers in determining potential areas of RAC audits.
- Monitor RAC progress at your regional RAC. Each of the four regional RACs maintains a website posting information on new audit focus areas and the status of a provider's audits.
- Perform an audit of your own billing practices—a snapshot audit may illustrate areas that need work.

If you are audited:

- Before you send records to the auditor, be sure to review them in a "self-review." Are there common themes? Are you coding with the correct documentation?

- Make copies of everything you send to the RAC auditor, and keep all of your documentation.

Here is information the person implementing the compliance plan should know:

- Staying on top of the RAC audits is important, as there are multiple policies and procedures governing RAC audits. The RAC can request a maximum of 10 medical records from a provider in a 45-day period. The time period that may be reviewed has changed from four years to three years.
- Responses are time-sensitive, and significant penalties may result if not handled properly. RAC contractors are paid on a contingency basis, which means they are only paid when they find either overpayments made by CMS or potential fraud by a provider.

The Academy offers resources to help members understand the RAC program, including an annual educational session at the annual meeting on Carrier Advisor Committees (CACs).

The Academy also provides updated information to members on the RAC program on our website at http://www.entnet.org/Practice/Recovery-Audit-Contractors.cfm. If you have questions regarding the RAC program, email the Health Policy team at healthpolicy@entnet.org.

The Doctors Company provides its members with MediGuard® core coverage, which protects against regulatory risks including Medicaid and Medicare RAC allegations. MediGuard® PLUS is an enhanced coverage available to members and includes higher limits and expanded features. For more information, visit www.thedoctors.com/mediguardplus.

Three Head and Neck Conferences in Hong Kong and Taiwan

Eugene N. Myers, MD, FRCS Ed (Hon)

Head and Neck Society: Taiwan

The Taiwan Head and Neck Society's 2011 Annual Meeting and International Conference took place at the Kaohsiung Chang Gung Memorial Hospital July 9-10, 2011. Organized by **Chih-Yen Chien, MD**, and his capable staff, the meeting was attended by 225 otolaryngologists and head and neck surgeons from Hong Kong, Japan, Korea, Taiwan, the UK, and the U.S. Conference Chair Chien, Prof. Sen-Tien Tsai, MD, president of the Taiwan Head and Neck Society, **Sheng-Po Hao, MD**, president of the Asian Society of Head and Neck Oncology, and Hung-Che Chiang, MD, PhD, Department of Health executive gave welcome addresses.

Among many interesting lectures were "The Evolution and Current Status of Selective Neck Dissection," by **Eugene N. Myers, MD, FRCS Edin (Hon)** USA; "Salvage Surgery for Recurrent Nasopharyngeal Carcinoma: Endoscope, Robot or Maxillary Swing?" by Prof. **William I. Wei, MD, FRCS**, Hong Kong; "Changing Paradigm in Skull Base Surgery–From Open to Endoscopic," by Dr. Hao, Taiwan; "Oncologic Results and Quality of Life in Patients with Hypopharyngeal Cancer after Transoral Laser Microsurgery," by Pen-Yuan Chu; MD, Taiwan; "Surgery of Recurrent Nasopharyngeal Carcinoma and Parapharyngeal Lymph Node Codes," by Jeng-Yuh Ko, MD, Taiwan; special lecture, "Salvage Supracricoid Laryngectomy with Cricohyoidoepiglottopexy after Radiation Failure," by **Meijin Nakayama, MD,** Japan; "Modern Thyroid Operation," by Feng-Yu Chiang, MD, Taiwan; "Advances in Knowledge in Salivary Gland Neoplasms," by Prof. Patrick Bradley, MBA, DCh, FRCS, UK; and "Management of Patients with Nasopharyngeal Cancer," by Professor Wei.

(I to r) Prof. Wei and Dr. Myers, at the Taiwan Head and Neck Society Meeting.

A panel discussion on the "Application of the ALT Flap in the Head and Neck Reconstruction" featured Ming-Huei Cheng, MD, Taiwan. Other panel discussions included: "Oral T Flap in Head and Neck Reconstruction" and "Discussion on Current Trends and Management of Locally Advanced Head and Neck Cancer." The robust poster session included sections on head and neck, nasopharyngeal carcinoma, oral oncology, and case reports. Prof. Tsai gave closing remarks.

The outstanding social events included a party for the guest faculty at the elegant restaurant, Francais, and a banquet for the meeting registrants. Overall, Dr. Chien did an excellent job of organizing a very complex, multinational, and multispecialty meeting.

Head and Neck Course: Hong Kong

The Head and Neck Course 2011: Common Intraoral Pathologies, an annual course for head and neck surgeons, took place August 25-26, 2011, at the beautiful facilities of the Queen Mary Hospital, Hong Kong, attended by 189 registrants from Hong Kong, China, and Singapore. **Jimmy Y. W. Chan, MD**, chief of the head and neck surgery division, University of Hong Kong Li Ka Shing Faculty of Medicine, was course director. A plastic surgeon by training, Dr. Chan is active in the surgical management of head and neck cancer. Li Shu Pui Professor of Surgery, and Dr. William Wei, who is emeritus chair of the otorhinolaryngology department, lectured on "Surgery for Malignant Oral Lesions." Dr. Myers lectured on the "Evolution and Current Status of Selective Neck Dissection," and Dr. Chan lectured on "Reconstruction of Intra-Oral Defects and Surgery for Recurrent Tumor of the Oral Cavity." The second day featured live surgery of a patient with carcinoma of the buccal mucosa. Resection, selective neck dissection, and free flap reconstruction were successfully performed. Altogether, the course was well organized, interesting, and contemporary in the issues it dealt with.

(I to r) Dr. Myers and Dr. Chan, Hong Kong course director.

Skull Base and Head and Neck Surgery Congress: Taiwan

At the 19th Annual International Wu-Ho-Su Memorial Congress on Skull Base and Head and Neck Surgery, held August 27-28, 2011, at Shin Kong Wu Ho-Su Memorial Hospital, Taipei, Taiwan, 265 head and neck surgeons attended, including those from Japan, Korea, Philippines, Taiwan, and the United States. Sheng-Mou Hou, MD, the hospital superintendent, greeted the delegates with a clear message that set the tone for the meeting, indicating that the major problem with oral cavity cancer is that 1.5 of every 10 Taiwanese men chew betel nuts.

This is the leading contributor to buccal cancer, the most common type of cancer in Taiwan for men aged 22 to 24. In the last 10 years, about 5,400 newly diagnosed cases and 2,300 related deaths occurred annually from buccal cancer. Dr. Hao, professor and chair of the department of otolaryngology and the Congress chair, stated that the Congress scientific program covered all the important progress in modern head and neck and skull base surgery, including robotic surgery. A pre-congress workshop included neck ultrasound and narrow band imaging (NBI) practice on head and neck tumors and transnasal esophagoscopy.

The excellent international faculty gave outstanding lectures. "Development of Head and Neck Surgery: Past, Present and Future," by Dr. Myers, set the stage for a variety of interesting and contemporary topics such as "Skull Base Surgery for Cancer of the Ear and Temporal Bone, " by Prof. **Ken-Ichi Nibu, MD, PhD**, Japan; "Human Papilloma Virus and Oral Pharyngeal Cancer," by Prof. Myung Whun Sung, MD, PhD, Korea; "Laryngeal Cancer Conservation Surgery," by Prof. Alfredo Q. L. Pontejos, Jr., MD, PhD, Philippines; "Unusual Neck Dissection," by Prof. Chung-Hwan Baek, MD, PhD, Korea; "Prevention and Management of Radiation Dermatitis," by Li Lu Chang, Taiwan; "Improved Surgery Survival Among Oral Cancer Patients Taking Metformin for Diabetes Mellitus Control," by Dr. Chien, Taiwan; and a spectacular display of surgical skills and imagination: "Recent Advances in Mandibular Reconstruction," by Ming-Huei Cheng, MD, Taiwan.

Course faculty: Wu-Ho-Su Memorial Congress, Taiwan.

A great feature of this well-organized meeting was adequate time allocated for discussion of these papers. The wonderful social events included a welcome party at Shin Kong Life Southeast Building and the farewell party at the Ambassador Hotel's Star Club, featuring wonderful food and wine and karaoke singing long into the night.

World Medical Mission Cleft Lip/Palate Mission, Kijabe, Kenya

Jason C. Goodwin, MD
University of Missouri-Columbia
Department of Otolaryngology-Head and Neck Surgery, AAO-HNSF/Alcon Fnd. Humanitarian Resident Travel Grantee

I switched careers from my previous job as a military pilot to medicine in large part because I wanted to make a more direct impact on individual lives. Thankfully, I'm reminded daily of the positive effect physicians can have on people's lives. Often these reminders are small, although sometimes they can be striking. I saw striking examples of this positive effect on a recent mission trip to Africa. In October 2011, I had the opportunity to travel to Kijabe, Kenya, to work in the AIC–CURE International Children's Hospital. My program director, **C.W. David Chang, MD**, led a small team to perform cleft lip and palate surgeries in this small mountain town north of Nairobi.

While not a life-saving operation, these surgeries do offer children a new life. Each child had a unique, inspiring, and sometimes heartbreaking story. Unfortunately, there is a social stigma in Africa associated with these disorders, and abandonment is common. Mildred and Joyce are sisters, both born with bilateral cleft lip and palate. Following Joyce's birth, the father left the family and the village shunned the mother. She struggled to provide for her children. A local aid worker found her and brought her to Kijabe. We performed successful cleft lip repair on both sisters. Their mother's joy as she saw her children after surgery was priceless. The smile that broke through her reserved, stoic demeanor is a memory I will cherish for the rest of my life. I hope the surgery is the start of a more normal childhood for Mildred and Joyce.

Team members included Academy members Dr. Chang, **Eric J. Dobratz, MD, J. Cameron Kirchner, MD, Michelle B. Vessely, MD,** and me. My wife, Bobbie, and Diane Kirchner completed the team as support staff. We performed 58 surgeries during the two-week mission. The experience was invaluable. Cleft surgeries are not a routine part of our training program. Professionally, I was allowed to challenge my operative skills. Personally, this trip strengthened my conviction about humanitarian work. I was fortunate my wife could accompany me. We've often talked about involving our family in humanitarian work and are now looking for ways to include our young children as well.

Dr. Chong (right) conducted clinics in the halls.

Thank you to the Alcon Foundation and the AAO-HNS Foundation for their generous help in supporting humanitarian work around the world. Please contact humanitarian@entnet.org for questions about humanitarian efforts.

Healing the Children Mission to Colombia 2011

Jean-Paul Azzi, MD
New York Eye and Ear Infirmary

In October 2011, 28 volunteers from Healing the Children and I flew from JFK to Bogota, Colombia, on our way to Hospital Universitario Fernando Troconis, Santa Marta on the northern coast. The group included Academy members **Manoj T. Abraham, MD, Jean-Paul Azzi, MD, Andrew A. Jacono, MD, Arthur W. Menken, MD, Augustine L. Moscatello, MD,** and **Evan Ransom, MD**.

On the flight, the veterans briefed us on OR assignments, cleft repair techniques, and tips on how to make the most of our experience. Upon arrival the ladies of "UNIMA," a Colombian charity that cosponsors our mission annually, greeted us.

The team included administrators, technicians, nurses, pediatricians, anesthesiologists, and surgeons. Dr. Abraham, a facial plastic surgeon from Poughkeepsie, NY, led the surgical team, which included a second facial plastic surgeon, two otolaryngologists, a facial plastic surgery fellow, and a senior otolaryngology resident.

On Sunday, we evaluated 125 patients, of whom 70 were scheduled to have surgery over the next five days. Ages ranged from four weeks old to young adulthood, with most requiring either revision or repair of cleft lips and palates. Many of these children and their families traveled several hours over difficult terrain. Some traveled by foot or by donkey over days, and, after reaching Santa Marta, slept in the hospital's crowded quarters waiting for their scheduled surgery.

Healing the Children, with its goal of organizing humanitarian medical missions to perform surgeries on needy children around the globe, has made a lasting impact on the vulnerable and impoverished throughout the world. I feel fortunate to have contributed.

We helped so many grateful families in such a short period. I take with me vivid memories of a mother's joyful tears when first seeing her child after cleft lip repair. I know I speak for the entire team when I say we will continue to do everything we can to heal the children worldwide.

Dr. Azzi pre-operatively with his patient.

Drs. Azzi, Ransom, Menken, Moscatello, Jacono, and Abraham.

Cornerstone Foundation Mission Trip to Honduras

Thomas S. Higgins, MD, MSPH
AAO-HNSF/Alcon Fnd., Resident Travel Grantee

I was fortunate to be a part of a group based out of the Eastern Virginia Medical School (EVMS), including two attending otolaryngologists, **John T. Sinacori, MD**, EVMS, and **Kaalan E. Johnson, MD**, University of Cincinnati; an anesthesiologist, Matt Cecchini, MD; a scrub tech; a nurse; three residents; and two support personnel to venture down to Balfate, Honduras, for our fourth successful medical mission trip.

Loma De Luz patients were examined by an EVMS team.

The purpose of the trip—my second one with the group—was to provide medical and surgical otolaryngologic care to the indigent population near Balfate, on the north coast of Honduras, at Loma de Luz (Hill of Light) mission hospital. (See the ministry's website at www.crstone.org.) The Cornerstone Foundation was started in 1992 by Jeff McKenney, MD, a U.S. general surgeon, and now boasts a 50-bed hospital that treats 900 patients a month for general surgery and primary care. Specialty teams routinely visit the hospital to serve the community's specific needs.

Dr. McKenney had identified patients needing our specialty care and set up appointments to see us when we arrived. Many of the people had waited months and traveled long distances, occasionally on foot, to see us. This year, we took care of about 60 patients and performed 20 surgeries, including tonsillectomies, tympanoplasties, a parotidectomy, thyroidectomies, a first branchial-cleft anomaly excision, and oronasal fistulae repairs.

Fiesta in Balfate, Honduras.

The experience was outstanding. I learned a great deal about a culture with deep roots in tradition and faith. Because of the lack of resources, we often faced challenges. I learned to utilize what was available and do what was right for the patient. I am grateful for having the capabilities to help the Balfate, Honduras, community. To the AAO-HNS Foundation's Humanitarian Efforts Committee and the Alcon Foundation, thank you for the funding to allow me to participate in this wonderful opportunity.

Dr. Higgins met a Honduran family.

Subspecialty Certification in Pediatric Otolaryngology

Richard M. Rosenfeld, MD, MPH
President, American Society of Pediatric Otolaryngology

Subspecialty certification (subcertification) in pediatric otolaryngology was approved by the American Board of Medical Specialties (ABMS) in 1992. Additional work, however, was delayed while pediatric otolaryngology matured and accreditation of fellowships expanded. Leadership of the American Society of Pediatric Otolaryngology (ASPO) believes the time is right to explore the topic further. This article seeks to clarify related issues, recognizing that subcertification is an emotionally and politically charged topic, full of distortions and misconceptions that can sabotage constructive dialogue if not addressed directly.

What is subcertification?

Subcertification is offered by the American Board of Otolaryngology (ABOto) to recognize exceptional expertise and experience beyond that achieved with primary certification in otolaryngology. The ABOto (www.aboto.org) is authorized by the ABMS to issue subspecialty certificates in neurotology, sleep medicine, pediatric otolaryngology, and plastic surgery within the head and neck. Certificates are currently active in neurotology and sleep medicine. Outside of otolaryngology, the ABMS has approved pediatric subcertification for surgery, urology, dermatology, radiology, pathology, and emergency medicine.

Why implement subcertification in pediatric otolaryngology?

Subcertification benefits the general public and otolaryngology as a whole by recognizing an advanced level of training. As a logical sequel to fellowship accreditation, subcertification validates training through rigorous assessment. The pediatric otolaryngologist has education and experience beyond that afforded in residency in managing neonates and children with challenging problems, significant comorbidity, or both. Examples include genetic disorders; problems with voice, speech, language, and hearing; uncommon or complex congenital and acquired conditions involving the ear, head, neck, aerodigestive tract, laryngotracheal complex, or nose and paranasal sinuses; and opportunities to advocate for the child in the home, school, or institutional setting.

What is ASPO's role in subspecialty certification?

Part of ASPO's core mission is to develop educational standards for training and evaluating otolaryngologists who care for children. In the same way that ASPO has partnered with the ACGME to define standards for fellowship accreditation, ASPO would work with ABOto in developing standards for subcertification if consensus of all stakeholders is reached to proceed. Subcertification would not be a requirement for ASPO membership, nor would it be something done by ASPO; subcertification would be handled entirely by ABOto. ASPO would facilitate the process by working with ABOto to define the requirements, knowledge base, and certifying examination.

Does subcertification encourage fragmentation in otolaryngology?

Absolutely not. An elegant answer to this question was provided by **Michael D. Seidman, MD**, chair of the Board of Governors, in the April 2011 *Bulletin*: "We can argue that subspecialization is fragmenting medicine today, but I would suggest that this is a canard. In reality, it is market forces and local/regional referrals that create this chasm. There is a need for continued subspecialization within otolaryngology-HNS, but this evolution need not herald the demise of the generalist. Rather, the existence of one can strengthen the other." The key is ensuring that subcertification reflects a body of knowledge

above and beyond the primary otolaryngology certificate and is not based on surgical case logs. The latter is critical because about one-third of general otolaryngology practice includes children, and the surgery may overlap with that done by pediatric otolaryngologists.

Does subcertification restrict the practice of the generalist?

In theory it should not, because as stated in the ABMS Reference Handbook: "There is no requirement or necessity for a diplomate in a recognized specialty to hold special certification in a subspecialty of that field in order to be considered qualified to include aspects of that subspecialty within a specialty practice. Under no circumstance should a diplomate be considered unqualified to practice within an area of subspecialty solely because of a lack of subspecialty certification. Such special certification is recognition of exceptional expertise and experience and has not been created to justify a differential fee schedule or to confer other professional advantages over other diplomates not so certified." In practice, however, entities that can restrict the practice of the generalist may use subcertification to deny care, reduce pay, accredit practice, or limit hospital privileges. Such abuses can occur in any discipline and require vigilance and education, not outright condemnation of the subcertification process.

Who could be eligible for subspecialty certification if implemented?

Building on the experience in neurotology and sleep medicine, there would likely be two pathways: a standard pathway requiring the applicant to complete an ACGME-accredited fellowship and an alternate pathway for a limited time for those who have not completed an accredited fellowship, but have significant clinical experience. Whereas the neurotologists were able to define an anatomical boundary (crossing the dura) to distinguish their surgical scope of practice from otology in general, there is no clear-cut boundary that readily distinguishes surgical procedures performed by a pediatric otolaryngologist from those in a general otolaryngology practice. Therefore, defining and differentiating a pediatric otolaryngologist from an ABO to primary certificate holder will be critical in developing pediatric otolaryngology subcertification.

What are the next steps?

The ASPO will work with its membership and all stakeholders to ensure that moving forward with subcertification is logical, appropriate, and meets the needs of those who would qualify for examination. Your comments and suggestions are welcome at richrosenfeld@msn.com.

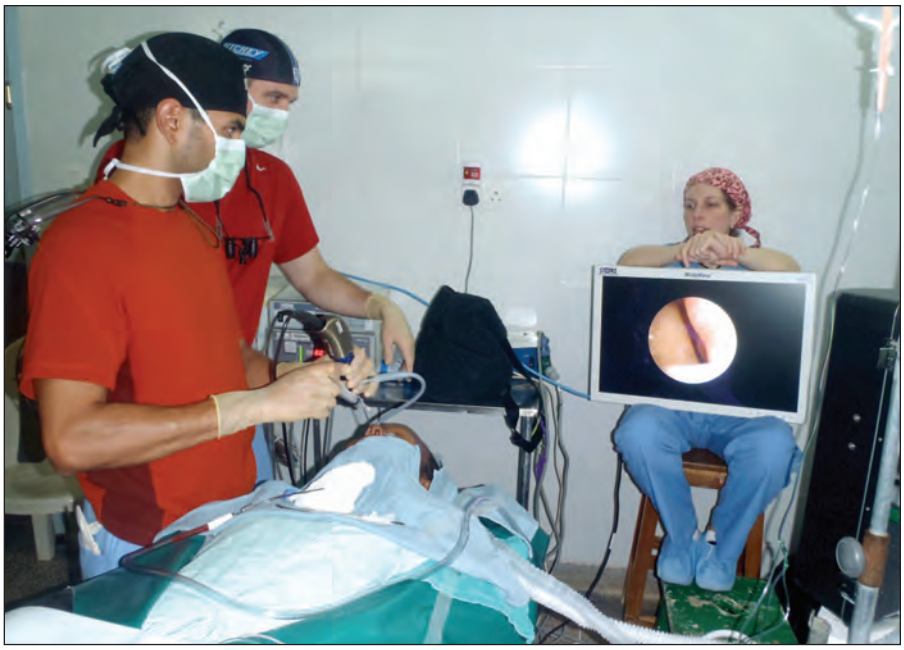
Dr. Netterville Leads Team to Malindi, Kenya

Sanjay Athavale, MD,
Vanderbilt University, AAO-HNSF/
Alcon Fnd., Humanitarian
Resident Travel Grantee

In November 2011, a large team from Vanderbilt University led by Academy President-elect **James L. Netterville, MD**, traveled to Malindi, Kenya, for a medical mission. Dr. Netterville, founder of More Than Medicine, has taken an annual team to Kenya for the past three years and previously, to Nigeria for 10 years.

Mumtaz J. Khan, MD, Kyle Mannion, MD, Sarah L. Rohde, MD, and **Mark van Deusen, MD**, joined Dr. Netterville and me. More Than Medicine and the Caris Foundation sponsored the trip, which lasted two weeks, from October 29 to November 11.

We spent our time at Malindi General Hospital and Tawfiq Hospital, which were quite different in their setup and capabilities with Malindi General being more of a rural hospital and Tawfiq a more "modern" hospital. This dichotomy gave us a greater appreciation for the changes underway throughout Africa.



Dr. Athavale and Dr. Mannion performed endoscopic sinus surgery while Dr. Rohde held the video monitor.

All 24 team members packed personal belongings into carry-on luggage, allowing us to pack more than 50 bags' worth of medical equipment into our checked luggage.

The caseload in Malindi, Kenya, was quite exciting, with many cases that are rarely seen here in the U.S. These included extremely large goiters, benign tumors of odontogenic origin, salivary

The entire team paused with 50 bags of medical equipment at the Kenya airport.

neoplasms, and benign skin lesions. I can honestly say that, on average, the smallest tumor we removed in Kenya was larger than the largest tumors we resect in the US.

For me and the majority of the team members, the trip was a life-changing experience. To see how much can be done with so little resources is truly amazing. Moreover, Dr. Netterville and his brother, Joseph D. Netterville, MD, a Nashville anesthesiologist, have made this mission such a well-oiled machine, that anyone who participates can learn quite a bit about teamwork.

For anyone interested in going on a medical mission trip, I would encourage you to do so. It teaches you as much about life and the strength of human fortitude as it does about surgery. It is a worthwhile experience that I hope every otolaryngology resident can undertake. Thanks to the AAO-HNSF Humanitarian Efforts Committee and the Alcon Foundation for supporting my life-changing trip to Malindi, Kenya.

An overhead shot captured the dedicated activity of the Tawfiq Hospital operating room.

China: A Delegate's Opinion about our International Outreach

Graciela Pepe MD, PhD, professor of otolaryngology, School of Medicine, Northeastern University, Argentina

I believe that we are people of choices. Our choices define who we are and what we stand for.

When I chose to be part of the official delegation of the AAO-HNS/F to China under the leadership of **K. J. Lee, MD**, I knew that I was challenging myself to make a journey of self-discovery, to make a leap in my evolution, leaving behind my prejudices and embracing diversity. Yes, I breathed deeply and immersed myself in the adventure, because I wanted to release those barriers that kept me separate and in control, letting my passion for work surge through me, connecting me to all beyond. I wanted to participate! And above all I wanted to participate in a cause bigger than myself in the land of an ancient Eastern civilization.

Today, already at home in Argentina, I would like you to know how grateful I am for Dr. Lee's invitation to enroll in the amazing experience we shared. It was memorable beyond words.

At the delegation, we were a group of people linked only by our different culture, our curiosity and that bit of courage we needed to face uncertainty. Americans, Canadians, Europeans, and Latin Americans with our eyes wide open to the wonders of a new world, trusting in Dr. Lee's leadership, linked by our membership in the AAO-HNS.

I am a world traveler, but I will treasure all my life this experience that opened the way to robust and candid relationships. In China I've taken notice that we share a particular stage of life, that time when we begin to feel the rightness, even the necessity, of sharing.

I have learned from Dr. Lee about leadership, wisdom, strength, endurance, and commitment to the highest goals of the AAO-HNS/F and to its members with generous giving of yourself and your time that I have truly appreciated and admired. From the delightful lady who is Dr. Lee's wife, Linda, I have learned about loyalty, about unconditional love. Thanks again to both of you!

"At the delegation, we were a group of people linked only by our different culture, our curiosity and that bit of courage we needed to face uncertainty. Americans, Canadians, Europeans, and Latin Americans with our eyes wide open to the wonders of a new world, trusting in Dr. Lee's leadership, linked by our membership in the AAO-HNS/F."

I've learned from Catherine Lincoln, from her gestures and kindness, from her work toward the common good and genuine interest in people, I've learned from her infinite patience and tolerance with everybody. She has my warmest feelings of gratitude.

I've learned from our Chinese colleagues about medicine, about different approaches to get the best for our patients sharing with us the same passion for work well done.

I've learned from my peers about sharing feelings and joyful impressions allowing us to stretch outside the box, opening ourselves to new ways of doing the same thing. From enjoying different forms of art at the magnificent museum of the "treasure island," to tasting unusual food in a night market of Taipei (and dare to compare the experience to some delicious plates at Jean Georges or Alain Ducasse in New York City), to pampering ourselves with sophisticated treats at the iconic Peninsula Hotel of Hong Kong.

3rd World Chinese ENT Conference, Kaohsiung, Taiwan: Academy delegation: l. to r. Catherine R. Lincoln (Academy staff,) Prof. Fei-Peng Lee, MD (President, Taiwanese ENT Society,) Omar E.M. Abdullah, MD, FRCSC (Canada,) Prof. Graciela Pepe, MD (Argentina,) past president KJ Lee, MD, Regional Advisor for the Pacific Rim and delegation leader, H. Russell Semm, MD (USA,) Arcadio A. Munoz, MD and Mrs. Munoz (Chile.)

I've learned from our guides, Lili and Maria, about kindness and commitment and sacrifice. They were with me until the last minute at the airport, giving me the gift of their company until almost the departure. (Probably they did not trust too much in my ability to follow the rigid custom rules—with two passports in my hands.)

Everything was exciting, a true intoxication of the senses, a wonderful stimulus for our creative minds, and the ignition of a passionate energy to connect, express, and communicate. It began with Dr. Lee's letter of invitation some months ago, our enrollment, his ability to light the spark of his passion for the AAO-HNS/F and scattering that light in all directions.

Hopefully many people in the future will have the chance to live a similar experience, hopefully the spark will ignite the blaze, transforming this unforgettable experience in the beginning of something really great, a community of ENT doctors in the world, setting aside the story of fear, struggle and competition, naturally engaged, seeking to contribute to a common cause, under the aegis of the AAO-HNS/F.

Hopefully the AAO-HNSF will articulate the WE story around the world.

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POSITION NUMBER: J0010781

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POSITION NUMBER: J0020146

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For further information, please contact: **Gary D. Josephson, M.D., Office: 904-390-3690, Cell: 904-226-1231 or gjosephs@nemours.org. Nemours Children's Clinic, 807 Children's Way, Jacksonville, FL 32207**

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Check www.entnet.org to register for May 6-8, 2012 BOG Spring Meetings and OTO Advocacy Summit

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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The University of Texas Health Science Center at Houston
Medical School

UTMSH is an equal opportunity employer.

ACADEMIC HEAD & NECK SURGEON
West Virginia University

The Department of Otolaryngology at West Virginia University is seeking a fellowship-trained head and neck surgeon to expand our well established head and neck oncology service. Expertise with both ablative and microvascular reconstructive procedures is desired. 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 scientists.

West Virginia University is located in beautiful Morgantown, which is rated one of the best small towns in America in regard to quality of life. Morgantown is located 80 miles south of Pittsburgh and three hours from Washington, DC. The position will become available in October 2011 and will remain open until filled. The WVU Health Sciences Center is a smoke free campus. West Virginia University is the recipient of an NSF ADVANCE award for gender equity.

Contact:
Hassan Ramadan, MD
Department of Otolaryngology
R.C. Byrd Health Sciences Center
Morgantown, WV 26506-9200
Telephone: (304) 293-3233; Fax: (304) 293-2902
e-mail: hramadan@hsc.wvu.edu
West Virginia University is an EOE/AA employer.

University of Missouri
Department of Otolaryngology—
Head and Neck Surgery

Seeks clinicians, teachers, and researchers who are personable, energetic and innovative to join a rapidly growing and collaborative group of physicians. A Faculty opportunity at all academic levels (Assistant/Associate Professor or Professor or Clinical Assistant/ Associate Professor or Clinical Professor) is available in **Head and Neck Surgical Oncology**. Title, track, and salary are commensurate with experience.

- Competitive production incentive
- Research interests encouraged and supported
- New outpatient clinic with state-of-the-art equipment and ancillary services
- Well established and expanding hospital system
- Live and work in Columbia, ranked by *Money* magazine and *Outside* magazine as one of the best cities in the U.S.

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).

Full Time Faculty Opportunities
University of Rochester Medical Center

Laryngologist
BC/BE, fellowship trained or equivalent experience laryngologist at any rank is sought to help build a nationally prominent laryngology and voice practice. Applicants should have a strong interest in clinical care and academic teaching. Protected research time and resources are available if candidate seeks a career as a clinician-scientist.

Pediatric Otolaryngologist
BC/BE, fellowship trained pediatric otolaryngologist at any rank is sought to practice at the Golisano Children's Hospital. This position offers excellent opportunities to practice the full range of the specialty in state of the art facilities. Resident teaching is expected and scholarly activities strongly encouraged. Protected research time and resources are available for candidates seeking a career as a clinician-scientist.

General Otolaryngology
BC/BE otolaryngologists with broad clinical interests are sought to develop a general otolaryngology practice in a community setting with full academic support. Protected research time and resources are available for clinician-scientists.

Our robust clinical practice and training program is affiliated with the University of Rochester Medical Center's Strong Memorial Hospital. The clinical office is located in a new facility opened in 2004. These are excellent opportunities to practice with an established group of academic faculty who already have practices in all Otolaryngology subspecialty areas, in a growing academic department.

The University of Rochester is an affirmative action/equal opportunity employer and strongly encourages applications from women and minorities.

Interested candidates should send their curriculum vitae and letter of interest to:

Shawn Newlands, M.D., Ph.D., M.B.A., F.A.C.S.
Professor and Chair
Department of Otolaryngology
Strong Memorial Hospital
601 Elmwood Avenue
Box 629
Rochester, NY 14642
(585) 758-5700
shawn_newlands@urmc.rochester.edu

OTOLOGIST / NEUROTOLOGIST

Seeking an experienced, fellowship-trained otologist/neurotologist to replace a retiring senior partner at the world-renowned Shea Ear Clinic in Memphis, TN. The **Shea Ear Clinic** was founded in 1926 and is a tertiary referral otologic clinic that specializes in the treatment of all diseases of the hearing and balance system, including chronic otitis media, stapedectomy, cochlear implantation, and inner ear perfusion. We are an extremely successful and innovative four-physician private practice with our own outpatient surgery center and hearing aid center. We currently have three otologists and one general otolaryngologist. Our state of the art audiology department has three Aud's and one audiology tech. Clinical appointments are available at the University of Tennessee Department of Otolaryngology – Head and Neck Surgery and teaching of residents is encouraged. Major procedures such as acoustic neuromas are performed at one of several large local hospitals.

Extremely competitive salary and benefits plus fast track to partnership, generous signing bonus, and relocation package. Memphis is a major regional medical center that serves patients from the mid-south and beyond. Memphis offers a laid-back lifestyle with a low cost of living and small town southern hospitality, but big-city amenities, professional sports, good schools, and many cultural attractions.

Please reply ASAP to

john.emmett@sheaclinic.com

UNIVERSITY OF ILLINOIS
Hospital & Health Sciences System
Otolaryngology

The Department of Otolaryngology-Head & Neck Surgery of the University of Illinois at Chicago and the University of Illinois Hospital and Health Sciences System has immediate openings for the following positions:

OTOLARYNGOLOGIST-HEAD AND NECK SURGEON

The Department of Otolaryngology-Head & Neck Surgery is recruiting a fellowship-trained Head and Neck surgeon. This is a faculty position with open rank and tenure, to be determined commensurate with experience and interest. Duties include providing direct patient care and supervising residents and medical students. Experience with microvascular surgery and robotic surgery preferred. For fullest consideration, apply by March 15, 2012.

OTOLARYNGOLOGY HOSPITALIST

The Department of Otolaryngology-Head & Neck Surgery is seeking a board certified or eligible otolaryngologist to function as a hospital-based consultant and surgeon at The University of Illinois at Chicago-Medical Center. The duties of this position include inpatient adult consultations and surgical procedures derived from these consultations, as well as interacting with our hospital-based resident clinic. The hospitalist will work with residents in the department and will assume a significant teaching role. We endeavor to make this position flexible to allow academic pursuits depending on training and qualifications. No call required. An individual might combine a significant basic or clinical research program with hospitalist duties. Must be currently licensed to practice in Illinois. For fullest consideration, apply by March 15, 2012.

Interested applicants for these positions should send their curriculum vitae to:

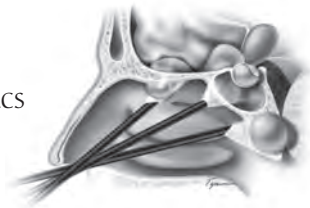
J. Regan Thomas, MD
Francis L. Lederer Professor and Head
Department of Otolaryngology-Head & Neck Surgery (M/C 648)
University of Illinois at Chicago
1855 West Taylor Street, Room 2.42
Chicago, IL 60612
Phone: (312) 996-6582, Fax: (312) 996-1282
Email: ENTHR@uic.edu
www.otol.uic.edu

The University of Illinois at Chicago encourages applications from women and minorities and is an AA/EEO employer.

The University of Illinois at Chicago is a major research university offering the cultural, business and entertainment opportunities you can only find in a world-class city. It is one of the top 200 research-funded institutions in the world. For more information, please visit www.uic.edu.

May 18 - 19, 2012 • New York City

Advanced Endoscopic Skull Base and Pituitary Surgery



COURSE DIRECTORS:
Vijay K. Anand, MD, FACS
Theodore H. Schwartz, MD, FACS

GUEST FACULTY:
John Jane Jr., MD
Charles Teo, MD

2-DAY COURSE DESCRIPTION: This course is a comprehensive overview of the newly emerging field of endoscopic skull base surgery combining didactic sessions with hands-on cadaver dissection. At the completion of this course, participants should be well equipped to start utilizing these approaches in their own practices. Endoscopic instruments and surgical navigation equipment will be available to participants for use on fresh cadavers during laboratory sessions. Participants will have an opportunity to discuss difficult cases with the faculty during panel discussions. Early registration is highly recommended.

LOCATION: Weill Cornell Medical College
1300 York Avenue, New York, NY 10065

INFORMATION: Course Coordinator
Tel: 212-585-6800
email: jeg9059@nyp.org
www.cornellneurosurgery.org

Weill Cornell Medical College
NewYork-Presbyterian
Weill Cornell Medical Center

Pittsburgh Ear Research Foundation
Division of Otology Research and Neurotology
Allegheny General Hospital
Pittsburgh, Pennsylvania
presents

Temporal Bone Microanatomy and Hands-On Dissection Workshop

April 13-14, 2012
June 22-23, 2012
October 26-27, 2012

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

Registration Fee:	$400
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, 320 East North Ave., Pittsburgh, PA 15212, by phone at (412) 359-4952, by e-mail at **tcochran@wpahs.org** or by fax (412) 359-8218.

Special Thanks To Our IRT Partners

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.

AAO-HNSF IRT
INDUSTRY ROUND TABLE

For more information on support opportunities, please contact:

Peter Taylor, MBA
Senior Manager, Corporate Relations
Phone: 1-703-535-3714
Email: ptaylor@entnet.org

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As of January 2, 2012

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

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*Independent research completed 11/08 by Kelton Research